University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 4 July 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:	Kate Rayns – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	John Jameson – Deputy Medical Director Carolyn Fox – Chief Nurse Darryn Kerr – Director of Estates and Facilities
Date of meeting:	27 June 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 27 June 2019:

- **Changes to Patient Partner Attendance at Board Committees** – QOC endorsed the proposed changes to the Committee's Terms of Reference, noting that three non-voting co-opted Patient Partners would be attending QOC meetings with effect from July 2019, and that this development was consistent with the emphasis on the Trust's Quality Strategy. The proposals were recommended for Trust Board approval on 4 July 2019.

- **7 Day Services Update** – Dr D Barnes, Deputy Medical Director attended to present paper E, updating QOC on the 7 Day Services Self-Assessment process and seeking the Committee's endorsement to submit the June 2019 Board Assurance Framework to NHS England ahead of the 28 June 2019 deadline. QOC members noted that Priority Clinical Standards CS05 and CS06 – as defined in the report – were 100% compliant, but overall compliance with standards CS02 and CS08 stood at 77% and 95% (respectively). In discussion on the report, QOC also noted the intention to implement a more targeted approach to the second audit of 2019, and requested that an increased focus on assurance and performance trends be incorporated into the narrative. Following discussion, QOC endorsed the 7 Day Services Self-Assessment and recommended it for Trust Board approval on 4 July 2019. A copy of paper E is appended to this meeting summary.

- **Annual Fire Report 2018/19** – the Director of Estates and Facilities introduced paper F, briefing QOC on the improving position in respect of Fire Risk Assessments, Fire Warden training, face-to-face and e-learning fire safety training compliance, 4 reported fire incidents, unwanted fire signals, prioritisation within the Capital Programme and visits conducted by the Leicestershire Fire and Rescue Service. Members noted that the format of this report was expected to change in 2019/20 to increase the emphasis upon the Trust's buildings, staff and processes rather than the activities of the Fire Safety Team. Following discussion, it was agreed to develop targets for the number of Fire Wardens to be trained in each area. The Director of Safety and Risk commented that the UHL Health and Safety Committee had not consistently received quarterly updates on Fire Safety, noting in response that the Deputy Director of Estates and Facilities would be addressing this matter, going forwards. For 2019/20, it was noted that the Trust would be increasing the focus on fire evacuation training. QOC endorsed the Annual Fire Report for 2018/19 and recommended it for Trust Board approval on 4 July 2019. A copy of paper F is appended to this meeting summary.

- **CQC Statement of Purpose** – paper G, as presented by the Chief Nurse, sought QOC's endorsement of a proposal to re-classify Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital

as satellite outpatient clinics and register these three premises under UHL's headquarters at the Leicester Royal Infirmary under Rule 8(a) of the CQC's guidance: "*What is a 'location'? Guidance for providers and inspectors".* QOC endorsed the two recommendations as set out in section 2.1 of paper G and recommended these for Trust Board approval on 4 July 2019. A copy of paper G is appended to this meeting summary.

- **Temporary Closure of Immunology Service to New Referrals –** Mr M Archer, Head of Operations, CSI and Dr L Barton, Consultant Haematologist attended the meeting to introduce paper H, briefing QOC on the operational pressures within UHL's Immunology and Allergy Services as a result of a deteriorating staffing position which was also being mirrored nationally. Assurance was received in relation to the continuation of the Immunology Laboratory, Paediatric Immunology and the Allergy Service, but the Committee was requested to endorse a proposal to close the Adult Immunology Clinical Service to new referrals for a period of approximately 9 months (between September 2019 and June 2020). Appendix 1 set out the Task and Finish Group Action Plan. QOC members sought and received additional information regarding the interim arrangements for new patients, the scope for training and developing UHL's own staff to mitigate this workforce gap, and opportunities for private sector providers to undertake the clinical workload. It was also noted that the service would be 'switched on' again 3 months ahead of the substantive Consultant returning to work. Following due consideration, the Committee endorsed the proposal to close the Adult Immunology Clinical Service to new referrals for a period of approximately 9 months. The Committee requested that the position be kept under continual review with a view to re-opening this service as soon as reasonably practicable.

- **Maternity Staffing Report** – the Chief Nurse introduced paper I, briefing the Committee on the results of the 2019 Birthrate Plus® acuity tool used to assess Midwifery and support staffing levels, which had identified a shortfall in maternity staffing of 20 Registered Midwives and 10 Midwifery Support Workers. During discussion on this item, the Committee noted that Midwifery staffing levels were triangulated with other patient experience and quality and safety data in the same way as nurse staffing. Opportunities were being explored to strengthen the role of Midwifery Support Workers within post-natal services, in line with best practice and a competency based training programme was in place to support this workforce group. The Committee received and noted the report and also agreed to continue to receive separate reports on maternity staffing for the 2019/20 financial year.

- **Nursing Accreditation and Assessment Update** – the Chief Nurse introduced paper J, outlining UHL's Adult Inpatient Ward Quality Assessment and Accreditation Framework, expanding upon the significant benefits of mainstreaming such a system and describing progress with the initial roll-out phase. Discussion took place regarding the early self-assessment returns and how these would be triangulated with patient and staff survey data, Friends and Family test results, scorecards, complaints, incidents, patient harms and known challenges within particular areas. Assurance was provided that the Framework applied to the whole team in each ward area, including the way that each professional group interacted with each other, eg handovers, Board and ward rounds using a Multi-Disciplinary Team approach. The Chief Nurse expressed her confidence that the first wards to receive 'triple green' status (three concurrent green assessments) would be seen at an early stage in the programme. These wards would then be invited to present to the panel and consideration would be given to awarding them 'Caring at its Best' status. QOC commended the report and looked forward to receiving further updates on the Framework at future meetings.

- **Patient Safety Report** – the Director of Safety and Risk introduced paper K, updating QOC on the following topics: (a) anticoagulation and plans to address GP concerns in relation to bridging plans for those patients whose anticoagulation treatment had to be suspended ahead of interventional procedures, (b) an update on reports published by the Healthcare Safety Investigation Branch, and (c) a safety issue relating to 'who's in charge' within clinical settings. The Director of Safety and Risk also updated QOC on a 'Never Event' (as discussed during the earlier joint session with People, Process and Performance Committee members) and the Patient Story (SUI) which was due to feature at the Trust Board on 4 July 2019. The parents of child KS (who passed away in 2015) were due to attend this Board meeting to present their story in person and QOC acknowledged the significant contribution that this family had made towards UHL's organisation learning.

- **NICE Guidance** – the Chief Nurse introduced paper L, briefing the Committee on the arrangements for

reporting and monitoring UHL's compliance against NICE guidance. The report was received and noted.

Items for noting

- **Radiology GIRFT (getting it right first time) report**;
- **CQUIN and Quality Standards Update, and**
- **Clinical Coding and Data Quality Update.**

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Changes to the QOC Terms of Reference;
- 7 Day Services submission to NHS England;
- Annual Fire Report 2018/19, and
- CQC Statement of Purpose.

Items highlighted to the Trust Board from this meeting:-

- Temporary closure of the Adult Immunology Service to new referrals.

Matters referred to other Committees:

- None.

Date of next meeting:	25 July 2019

Seven Day Services

Dan Barnes Deputy Medical Director and Vicki Hing Project Manager

Executive Summary **Paper E**

Context

All Acute Providers are required to undertake a Seven Day Service Self-Assessment against the 4 priority Clinical Standards on a biannual basis which then forms the basis of a Board Assurance Framework (7DS BAF) for sign off by the Trust Board before submission to NHSE. The June 7DS BAF requires submission by 28th June 2019.

Priority Clinical Standards

CS 02 (Time to Consultant Review) is non-compliant at 77%.
CS 05 (Diagnostics) and CS 06 (Key Consultant Interventions) are compliant.
CS 08 (On-going review) will be reported non-compliant as all 4 elements need to meet 90% for compliance.

- Patients requiring once daily review – Weekdays 97% Week end days 87%
- Patients requiring twice daily review 100% compliant week days and weekends.

The four priority standards were met in the specialist network specialities – PICU, STEMI Heart Attack, Hyper Acute Stroke, Emergency Vascular services.

Non-Priority Clinical Standards

With respect to the other 6 Clinical Standards:
CS 01 (Patient experience) – Compliant
CS 03 (MDT) – Partially compliant. (Not all MDT Board Rounds are 7 days)
CS 04 (Handover) – Compliant
CS 07 (Mental Health) – Compliant (requires further work in measurement)
CS 09 (Transfer to Primary Community and Mental Health) - Significant improvement over last 2 years not completely compliant over all 7 days.
CS 10 – Requires further work for next submission

Input Sought

- To sign off the Board Assurance Framework for submission to NHSE as an accurate and true reflection of delivery from March 2019 7DS Survey.
- To endorse and support the recommendations made in the attached report.

For Reference

Edit as appropriate:

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

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

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

Organisational Risk Register	Not applicable
Board Assurance Framework	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: [TBC]

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

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

Seven Day Services Board Assurance Paper for EQB June 2019

Author Vicki Hing Project Manager

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1. Context

The 7 Day Service National Survey covers the management of patients admitted as an emergency, measured against the four priority standards.

Priority Clinical Standards	Standard 2: Time to Consultant Review Standard 5: Diagnostics Standard 6: Consultant directed interventions Standard 8: On-going daily consultant-directed review

These priority standards have been selected from 10 clinical standards developed by the NHS Services, Seven Days a Week Forum as they are most likely to have the greatest impact in tackling variations in mortality, patient flow and experience.

Standard 2
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

Standard 5
Hospital inpatients must have scheduled seven-day access to consultant-directed diagnostic tests and completed reporting will be available seven days a week:
• Within 1 hour for critical patients
• Within 12 hours for urgent patients

Standard 6
Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols

Standard 8
All patient with high-dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Progress towards standards measured using a 7 Day Service Self-Assessment tool. A sample of case notes reviews for standards 2 and 8 across a 7 day period and complete a self-assessment for standards 5 and 6.

2. Methodology

Notes were audited using the National 7 Day Services Survey Tool. They were Emergency Admissions between Weds March 6th 2019 and Tues March 12th 2019 inclusive. 406 sets of notes were audited. Clinical Standard 02 Time to First Consultant Review and Clinical Standard 08 On-Going Review were audited manually retrospectively over 5 days between May 14th and 21st. The audit was undertaken

by Vicki Hing Project Manager and 13 Junior Doctors ranging in Grade from FY2 to Registrar from Medical and Surgical specialties.

The Notes audited were randomly selected starting with every 5th admission across the Trust. If the notes were not available at the time of requesting them, another set were picked from admissions 1-4.

Data regarding Date and Time of: Arrival at hospital, Admission to hospital and Discharge from hospital were taken from a download from the Hospital System. Data regarding Date and Time of First Consultant Reviews and On Going reviews were manually collected from the notes. However in some cases for medical admissions NerveCentre was used.

The data was entered directly onto the National 7 Day Service Self-Assessment Tool.

3. Assumptions made for the National Survey Tool Audit

3.1 Assumptions made during the medical notes audit for Clinical standards 02 and 08 and self-assessment of Clinical standards 05 and 06 are detailed in **Appendix 1**

4. Results

4.1 Overall Trust Results 4 Priority Standards

CS02			CS05	CS06	CS08		
Week Days	Weekend	**Overall**			Week Days	Weekend	**Overall**
					Twice Daily Review		
					100%	100%	100%
					Once Daily Review		
75%	81%	77%	100%	100%	97%	87%	95%
NHSE Rating Non- Compliant			NHSE Rating Compliant		NHSE Rating Non- compliant		

Clinical Standard 08 will be reported to NHSE as not met. 90% compliance was not achieved at the weekends (detail in section 4.6)

4.2 Clinical Standard 02 Consultant Review – by Speciality

All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

RAG Rating Compliance for tables

0%-74%	75%-89%	90%-100%

Table 1 shows a breakdown of compliance by speciality. The target is 90% compliance.

	Total Audited	No. Non-compliant	% Complaint	*Trend and compliance from 2018		Consultant Review After 14 hrs
UHL	406	93	**77%**	⇔	77%	77
LRI	265	45	**83%**	↓	86%	37
LGH	59	23	**61%**	↓	69%	21
GGH	82	25	**70%**	↑	67%	19
Emergency Medicine	107	4	**96%**	↑	90%	2
Geriatric Medicine	26	4	**85%**	↓	88%	4
Stroke Medicine	33	3	**91%**	↓	100%	3
MEDICINE LRI	166	11	**93%**	↑	90%	9
General Surgery LRI	28	17	**39%**	↓	69%	14
General Surgery LGH	42	21	**50%**	↓	64%	20
Urology LGH	11	4	**64%**	⇔	64%	3
Total LGH Surgery	53	25	**53%**	↓	64%	23
SURGERY	81	42	**48%**	↓	66%	37
Paeds Medicine	23	4	**83%**	⇔	83%	4
Paeds Surgery	6	0	**100%**	↑	60%	0
PICU	3	0	**100%**		**NA**	0
PAEDRIACTRICS	32	4	**84%**	↓	88%	4
Gynaecology	11	4	**64%**		**NA**	4
Obstetrics LRI	8	0	**100%**		**NA**	0
Obstetrics LGH	3	0	**100%**		**NA**	0
Total Obstetrics	11	0	**100%**		**NA**	0
Obs and Gynae	22	4	**82%**	↓	93%	6
Cardiology	35	15	**57%**	↑	50%	9
Respiratory	38	10	**74%**	↓	81%	10
CDU/CCU	73	25	**66%**	↑	64%	19
Oncology	6	0	**100%**	⇔	100%	0
Trauma and Ortho	5	0	**100%**	⇔	100%	0
ENT	3	1	**67%**	↓	75%	0
Vascular	9	0	**100%**		75%	0
Max Fax	5	2	**60%**		**NA**	1
Renal (LGH)	1	0	**100%**		50%	0
Neurology	2	1	**50%**		**NA**	1
Plastics	1	0	**100%**		**NA**	0
Other	32	4	**72%**	↓	85%	2

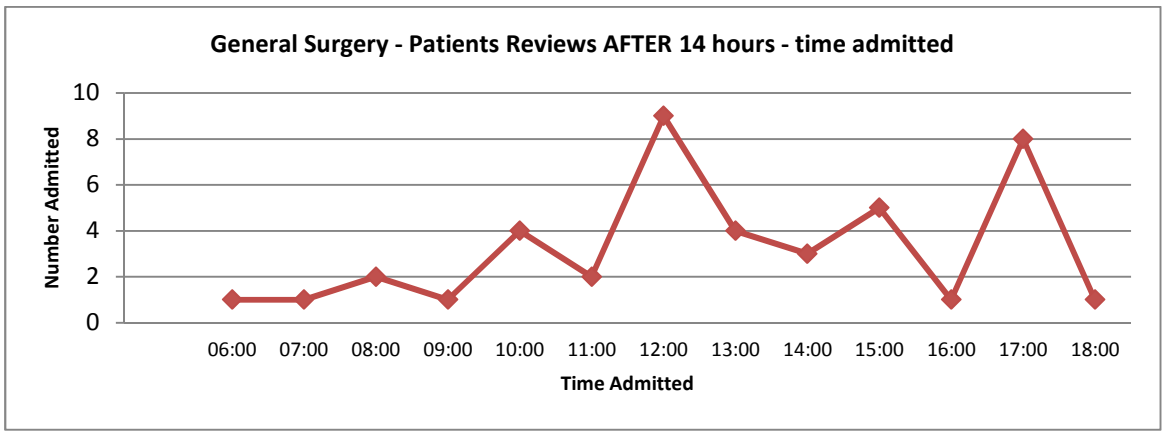
Table 1

Overall UHL show 77% compliance the same as 2018. The LRI and LGH show a slightly lower compliance and the GGH a slightly improved compliance.

Overall Medicine is complaint. Emergency Medicine is patients admitted into AMU. Geriatric Medicine was slightly under the 90% target.

General Surgery show a worsening position to previous audits, with the issue identified as the same for the last few years. With the exception of 3 patients, patients admitted between the hours of

08.00 and 17:00 were not seen by a consultant until the following day ward round starting at 08:00, therefore they were not reviewed by a consultant within 14 hours.



For the 4 non-compliant Paediatric medical patients, all were admitted late afternoon early evening and had a consultant review the following morning.
Previous audits analysed by NHSE have put Obs and Gynae together so there is no comparative data. 3 of the non-compliant Gynae patients were admitted late afternoon / early evening on a week day and reviewed the following morning by a consultant; one was admitted on Saturday afternoon and reviewed the following morning.

Out of the 35 Cardiology notes audited 4 were admitted to CCU of which all 4 were compliant. This means that the result for Cardiology in CDU would be 52% compliance.

Respiratory results showed a slight dip from last year at 74% compliance

Those services listed under “other” and also Paediatric Surgery were such small numbers that they are not a representative sample for the service on its own.
Vascular services are required to be fully complaint and recorded separately and all 9 patients audited were reviewed by a consultant within 14 hours.

Table 2 below shows Clinical standard 02 compliance over the last 4 years. There has been little movement between 2017 and 2019.

Audit Date	Compliance		
	Total	Weekday	Weekend
Mar-19	77%	75%	81%
Apr-18	77%	76%	77%
Mar-17	75%	75%	74%
Mar-16	46%	52%	48%

Table 2

The following Table 3 shows CS02 results for compliance by day of the week: Overall Mondays seem to have been one of the worst days and generally the weekends are slightly better.

ALL 3 SITES			
Day of admission	Total Audited	Non-Compliant	Compliant
Mon	62	19	69%
Tue	58	13	78%
Wed	75	15	80%
Thu	53	13	75%
Fri	62	16	74%
Sat	40	8	80%
Sun	56	9	84%
Grand Total	406	93	77%

Table 3

Appendix 2 Shows all main specialities and their compliance by day of the week in this format. Once data is split across each day the sample size becomes relatively small.

4.3 Patient made aware of diagnosis, management plan & prognosis within 48 hours of admission

Table 4 shows full compliance of patients being aware of diagnosis, management plan & prognosis within 48 hours of admission

	Admission Day						
	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Within 48 hours	61	56	73	51	58	40	55
% Within 48 hours	98%	97%	97%	96%	94%	100%	98%
Outside of 48 hours	1	2	2	2	4	0	1

Table 4

4.4 Clinical Standard 05 Diagnostics

Hospital inpatients must have scheduled seven-day access to consultant-directed diagnostic tests and completed reporting will be available seven days a week:
- Within 1 hour for critical patients
- Within 12 hours for urgent patients

The diagnostics listed are: ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.

As mentioned in section 3.2 no evidence is required for the Survey. As a Trust we have answered this section as Yes – and therefore show 100% compliance. However, this is really only in answer to the question "*Is diagnostic testing and reporting always or usually available*". To date we have not found a solution to measuring the standard against the criteria for critical, urgent and non-urgent patients.

For MRI Ultrasound and CT the data is not separated for Emergency and Elective patients.

The data does not distinguish between urgent and non-urgent.
To produce data would require a significant resource to match the CRIS Data against Patient Centre to separate out the patients on an emergency pathway.
On CRIS the patients are not categorised on the system as Urgent or non-urgent. This could be done but would again take resource and effort to complete.

For Upper GI Endoscopy there is 7 days a week in- reach service and the standard should be met.
Echo's are available 7 days are week but discrete data is not collected against the standard.
For Microbiology there is a 24/7 service including on call for Microbiology. Samples that are clinically urgent get turned around within the appropriate time for that particular test. – This varies from hours to days to weeks depending on the tests. All tests have their own Turnaround times.

4.5 Clinical Standard 06 Consultant Directed Interventions.

Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols

In the National Survey the Trust was asked:
"Do inpatients have 24 hour access to consultant directed interventions 7 days a week, either on site or via formal network arrangements?"
The following Interventions are listed:
Critical Care, Primary Percutaneous Coronary Intervention, Cardiac Pacing, Thrombolysis for stroke, Emergency Surgery, Interventional Endoscopy, Interventional Radiology, Renal Replacement, Urgent Radiotherapy.
All were answered as "**Yes – On Site – both week days and weekend days - 100% Compliance"**.

4.6 Clinical Standard 08 On-Going Review

All patient with high-dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Table 5 shows the number by day of patients requiring a twice daily review. These were few in number and 100% compliance was achieved.

Review Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of patients requiring twice daily reviews	8	6	6	1	2	4	4
Number of patients receiving twice daily reviews	8	6	6	1	2	4	4
% of patients receiving twice daily reviews	100%	100%	100%	100%	100%	100%	100%

Table 5

In Table 6 details Patients requiring Once Daily reviews

Review Day	Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday		
Number of patients requiring once daily reviews	156		163		161		173		166		116		102		1037
	Consultant	Delegate	Consultant	Delegate	Consultant	Delegate	Consultant	Delegate	Consultant	Delegate	Consultant	Delegate	Consultant	Delegate	
Number of patients receiving once daily review	118	35	98	61	83	76	121	45	82	79	58	43	52	36	987
Total reviews	153		159		159		166		161		101		88		987
% of patients receiving once daily review	98%		98%		99%		96%		97%		87%		86%		95%
2018	98%		99%		100%		97%		99%		85%		84%		94%

Table 6

Overall the Trust showed compliance of 95% - patients receiving daily reviews. There is variation on week days and weekend days. This standard is being met (with the assumptions made, as described in the methodology). However the weekend is just short of the required compliance. For the purpose of reporting to NHSE both week days and week end days are required to be compliant for the standard to be met. Therefore overall the standard will be reported as non-compliant.

Weekdays Total Compliance is 97%: Weekend Total Compliance is 87%

4.7 7 Day service and Urgent Network Clinical service

There is a requirement for the 4 priority standards to be met in the following specialities and reported separately: Hyper acute stoke, Paediatric Intensive Care, STEMI Heart Attack and Emergency Vascular Services.

All the notes audited for these services were compliant in both Clinical Standard 02 and 08, however with the exception of Stroke, there were a very small number of notes randomly chosen for PICU and STEMI Heart Attack, and a limited number in Vascular. However previous specific audits in these specialities have always shown compliance, and there is no evidence to show that this will have changed. Therefore for this submission all four areas will be reported compliant.

5. Conclusions and further information re four priority standards

5.1 Method of Collating Data Clinical Standards 02 and 08

The Survey regarding auditing of notes continues to be completed manually. Nerve Centre has the functionality to record time of first consultant review. In AMU and CDU this is now being used most the time, and some data was taken from the system. However until ALL admissions areas have NerveCentre, and all admissions are recorded on Nerve Centre, a manual audit will need to continue. In addition, Nerve Centre has the functionality to record on-going reviews. This is not used within the Trust.

5.2 Clinical Standard 02

In 2016 a detailed audit of General Surgery across both sites was undertaken. During the audit period the Surgeons at the LRI completed 2 ward rounds a day. During this audit Clinical Standard 02 was met in Surgery at the LRI. As a result it was determined that to meet the standard Surgery would need to conduct 2 ward rounds a day, the addition of an evening ward round to see any newly admitted patients. This has not to date been implemented and is reflected in the results for surgical patients.

Whilst Medicine is compliant with the standard there were 2 patients that were admitted late in the evening on the Friday and did not therefore see a consultant on AMU on that day. They were transferred to a medical ward in the night and the ward did not have a weekend ward round. Subsequently these patients were not seen by a consultant until Monday morning.

Respiratory services showed an improvement in meeting Clinical standard 02 in 2018 and CDU for respiratory is covered with consultant presence 7 days a week. It must be noted that consultants and registrars work together across CDU in respiratory and it is apparent that some patients are seen and admitted to a ward before a consultant review takes place.

Cardiology has consistently been unable to meet the standard. Capacity of the Consultants does not allow time for consistent consultant cover on CDU. Funding for further Cardiologists has been assigned but to date not appointed to. Until such time as the consultant numbers are increased no further improvement is expected.

Further work is currently taking place in measuring clinical standard 02 in CDU through the data generated from NerveCentre.

Initial data (to be validated) taken for a 15 week period November 18 – March 19 showed the following:

- 82% of all admissions had a senior review recorded on Nerve Centre (Consultant or Registrar)
- 94.5% of admissions with a stay greater than 14 hours had a senior review (Consultant or Registrar)
- 97.5% of those 14HR+ admissions, had a senior review (Consultant or Registrar) within 14 hours

However for Consultant reviews:

- 66.1% of admissions with a stay of 14+ hours had a consultant review recorded
- 48.8% of those were seen by the consultant within 14 hours

For Respiratory:

- 83.9% of admissions with a stay of 14+ hours had a consultant review recorded
- 66.3% of those were seen by the consultant within 14 hours

For Cardiology

- 42.1% of admissions with a stay of 14+ hours had a consultant review recorded
- 24.1% of those were seen by the consultant within 14 hours

5.3 Clinical Standard 05

Resource would be required to complete work on fully measuring against the standard. This currently is an issue of how our data is formed as it does not automatically measure against the criteria set.

5.4 Clinical Standard 08

Although as a Trust this standard was compliant overall – there was a variation across week days and weekends. In fact the week end days themselves were not compliant. In many cases this has been because there was not a clear management plan for the Weekend in the medical notes and therefore an assumption could not be made that care was delegated.

There were some areas of good practice that some services used to ensure that a weekend management plan for a patient was clear.

A separate sheet in the notes – a different colour – Specifically for the weekend.

A sticker in the notes – named – "weekend management plan".

Both these made it easy to identify what was planned for the weekend.

6. Other Clinical Standards

6.1 Clinical Standard 01 Patient experience.

Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.

For 2 years we have been able to differentiate the friends and family survey in our assessment units specific to the question re recommendation to family and friends. This information is broken down by day of admission. The information is consistently 92-98% for recommendation and has very little variation across week days and week end days.

Patient feedback is well evidenced, documented and acted upon via formal complaints, verbal complaints, GP concerns, NHS Choices, Patient Opinion, Friends and Family Test surveys (electronic and paper formats) and Message to Matron. These are not specifically identified by day of the week.

Involving Patients, family and carers in the patient's journey is key. Patients should be at the centre of any decision making and should be consulted at all stages of their care pathway. The Integrated

Discharge Team continues to work with clinical teams to promote the 4 key questions in their Clinical areas.

- What is the matter with me
- What is going to happen today
- What is needed to get me home
- When am I going home

6.2 Clinical Standard 03 Multidisciplinary Team review

All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

The Board and Ward Round Professional standards have been reviewed and updated. They aim to provide guidance to staff about the standards for Board Rounds.

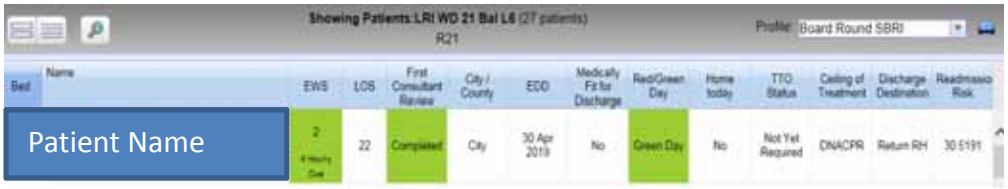
BOARD AND WARD ROUND PROFESSIONAL STANDARDS include:

Scheduled MDT Board round 5 days a week Monday- Fri AM 52 weeks a year. (Ideally 7 days a week)

- A minimum MDT Must be present
- Every patient must have a consultant review and approved management plan in place within 14 hours of arrival on the ward.
- Medical plans must include Estimated Date of Discharge, within this a Clinical Criteria for Discharge which is established and agreed with the MDT and reviewed daily.
- A priority order of addressing the sickest patients, potential patients to be discharged that day.

Minimum Team for MDT: Consultant/SPR, ward Manager/Deputy, discharge Coordinator, Trainee Doctor, Therapist (PT, OT), Integrated Discharge Team, Matron 2 times per week, Pharmacist (desirable).

A new easy view Board Round profile was launched on nerve centre in September 2018 to capture the 'next steps' in the patient's journey. The data captured in this field feeds directly into e-beds.



A complete data set received from CMGs re Board Rounds – see table 6 below. 95% of clinical areas are reported to have a ward/board rounds across the Trust Monday to Friday. However this reduces to 59% for Monday to Sunday.

100% of applicable CMG ward areas (63 wards) are reported to be using the Red2Green principles for highlighting delays in the patient's journey. However a recent Price Waterhouse Cooper audit on the process reported inconsistencies in the application and use of nerve centre.

This data is for ALL wards for all inpatients.

CMG	Number of Wards	Board Round % Mon-Fr	Board Round % Mon-Sun	Ward Round % Mon-Fri	Ward Round % Mon-Sun	Red2Green % applicable areas
ITAPS	3	100%	100%	100%	100%	N/A
ESM (SM)	16	100%	6.60%	93.30%	8.60%	100%
ESM (EM)	5	100%	100%	100%	100%	N/A
CHUGGs	19	100%	100%	100%	84%	100%
MSSK	9	100%	22%	100%	44%	100.00%
RRCV	19	50%	5.20%	84%	47%	100%
W&C	20	85%	55%	100%	70%	100%
CSI	Not Applicable No Wards					
TOTAL:	91	84%	42%	95%	59%	100%

Table 6

6.3 Clinical Standard 04 Shift handovers

Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

For Nursing Handovers the NerveCentre system is used. At UHL the Hospital at Night Model is implemented for handover from In and Out of Hours medical staff. A New Policy of clinical Handover is in place - implemented in 2018.

Each specialty will have an identified process that details the following for each type of handover.

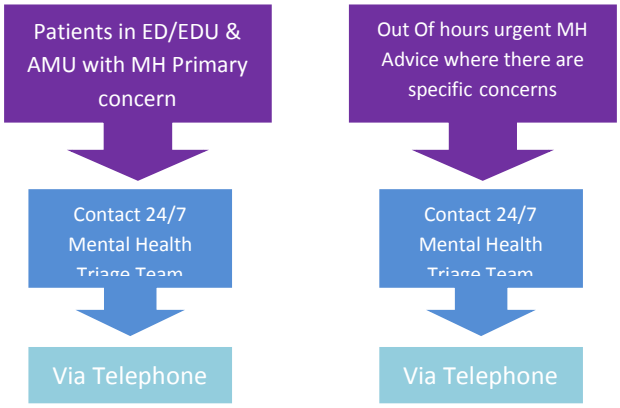
- Who participates
- When it occurs
- Where handover occurs
- How handover is to be conducted
- What information is to be relayed

The Hospital at Night Handovers have specific times and locations at each site. The model of SBAR is used to run the handover meetings:
SITUATION –i.e. Who is on shift – what are the staffing levels like?
BACKGROUND– i.e. What state is the hospital in at the moment. Any sickness / shortages on rota for shift starting. NerveCentre review (outstanding tasks). AMU Review
ACTIONS i.e. where will each team member be working?
RESPONSE i.e. which patients need attention?

6.*4 Clinical Standard 07 Mental Health*

Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.

A clear 24/7 referral pathway is in place for Emergency Patients



An audit of Adult Mental Health Care was undertaken in December 2017 and again in October 2019 to audit care of patients with mental health conditions who present to the ED and also our use (and standard of) completion of the mental health paperwork used in the ED (MH Blue Book).
The aim was to: Assess standard of patient initial assessment in the ED and referral on to the LPT Mental health Team.
The audit concluded: Good improvement and maintenance of standards in audit. Process seems to have become ingrained. Description was missing in only a couple of sets of notes. Difficult to assess wait time to see team. This needs an update to nerve centre which has been requested and will be part of future overall psychiatric liaison provision to UHL.
The Audit Report can be read in **Appendix 3**

6.5 Clinical Standard 09 Access to Community Primary and Social Care

Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Integrated Discharge Team

The Integrated Discharge Team (IDT) is a truly collaborative service bringing together employees from five Health and Social Care Organisations namely:

- Leicestershire County Council
- Leicester City Council
- Rutland County Council
- Leicestershire Partnership Trust (LPT) and
- University Hospitals of Leicester NHS Trust

The model is primarily focused on a multi-agency team providing a single point of access to the Trusts wards by providing expertise and advice in the safe and effective discharge of patients with complex discharge needs and acting as experts on discharge planning for the wards. The IDT aims to create a culture that focuses on up skilling and enhancing ward based staff involved in discharge.

The team were established in July 2017 and moved to a co-located area on level two Windsor building at the LRI in May 2018. The IDT hub provides hot desking facilities for both internal and external members of the team.

Discharge Coordinators. Each ward in the hospital should identify a ward coordinator who is responsible for overseeing admissions and discharges to the ward and responsible daily for the overall management of the ward. Some wards have a designated Discharge coordinator role that over sees the discharge coordination. More recently due to the recruitment difficulties ward Sisters have reviewed their skill mix and have created a Specific role to assist with discharge. The IDT recently designed some competencies and launched these over two study days - there have been 30 new recruits over recent months.

Pharmacy services to facilitate discharge (e.g. provision of TTAs within same timescales on weekdays and at weekends) TTO project in Speciality medicine looking at whole process saved time in dispensing and delivery of meds to wards. Now focussing on timeliness of writing of the medical discharge summary. Pharmacy services work across 7 days.

The TTO project was originally sponsored by Health Education England during 2017/18, with 7 Day Services funding. The Head of Nursing for Flow and Discharge is working in collaboration with the TTO project team to deliver an improved approach to TTO discharge medication.

The Project is now sponsored by Clinical Support and Imaging CMG.

The TTO project had 4 Key deliverables:

- Improve amount of TTO's being available **before midday.**
- Increase discharges **before 1400hrs.**
- Remodel the TTO Process.
- Increase number of Pharmacist Independent Prescribers (by 10).

The project activity commenced mid-March 2017.

Process mapping of the TTO activity was undertaken incorporating process improvement with stakeholders to deliver an agreed, revised TTO process.

The project was divided into 3 phases:

- **Phase 1** – Writing and approving the discharge summary
- **Phase 2** - Dispensing of the discharge medication
- **Phase 3** - Transport of the TTO medications to the wards.

Phase 2 and 3 have completed and sustained improvement. Phase 1 is the main focus for the project going forward

Physiotherapy and other therapies –There is cover for some wards at the weekends and recently the Frail elderly squad at the front door have therapists now 7 days a week.

Access to social and community care providers to start packages of care – We are able to refer to Social services across the 7 days. Work over the past year has piloted a number of different approaches with social services colleagues – from having an onsite approach to telephone support. Social workers try and attend a minimum of 2 board rounds per week in medicine to identify patients needing support and they proactively start to identify should packages be needed. The Carers Trust Discharge Response team on site 7 days a week – they are a bridging service for county patients. Wards are able to restart packages by phoning the care providers directly. We try to plan for discharge over the weekend from the base wards with weekend stickers , criteria led discharge etc. we have a small number of Discharge Practitioners that work across the emergency floor who cover a 7 day service who can access services that staff can go to if they are not aware of the processes.

Access to transport services. We can access TASL – Thames ambulance service ltd.

Red2Green was identified as a priority in the 2018/19 Quality Commitment:

Since 12th December 2016 the Discharge team has been working hard with our clinical teams on the introduction of the 'SAFER' Patient Flow Bundle and Red2green bed days approach across the hospital.

SAFER is a practical tool to reduce delays for patients in adult inpatient wards and blends five elements of best practice. When used in conjunction with the R2G bed days approach and followed consistently, length of hospital stay is reduced and patient flow and safety improves.

R2G bed days are a visual management system to assist in the identification of wasted time in a patient's journey and are used to reduce internal and external delays.

6.6 Clinical Standard 10 Quality Improvement

All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

Work is currently in progress with the Informatics team in looking at outcomes across 7 days including, Length of Stay, readmissions 7 and 30 days and weekday and weekend mortality.

A more comprehensive update for this standard will be delivered in the next submission in 6 months' time.

7. Recommendations

CS02 Surgical Services – For CHUGGS to review service level data with a view to describing more robust consultant review processes for newly admitted surgical patients.

CS02 Cardiology - to ensure that once the new cardiologist posts are appointed to that a consultant presence on CDU is part of the plan.

CS02 Respiratory - Conduct further work to establish why some patients are not seen by the consultant in CDU. Refine the data taken from NerveCentre relating to Time of First Consultant review (to be supported by Project Manager)

CS02 ESM – To investigate further the risk of patients being admitted late evening into AMU and transferred to a ward in the night, where no weekend ward round is planned. The consequence of which is that patients do not receive a consultant review within 14 hours, and more likely to be over 60 hours.

CS08 To establish an agreed format for a weekend management plan to be added to the medical notes, and implement across ALL specialities.

CS10 To deliver an update on this standard for the next submission

To identify numbers of missed documentation in the audit and send a communication to all Doctors to reiterate the requirement for all reviews in medical notes to be date and time stamped and clearly printed with Name and designation.

To publish the results of the survey relating to clinical standards 02 and 08 to CMGs for discussion and comment.

For agreement to be made where the focus for the next audit (due in 6 months) should be made or if indeed an audit of notes is necessary until 2020 Spring Summer

Submission to NHSE is completed and is recommended to be signed off by QOC.

University Hospitals of Leicester NHS Trust: 7 Day Hospital Services Self-Assessment - Spring 2019/20

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Overall compliance across the 3 sites for UHL was 77%. Main areas of non compliance are General Surgery and Cardiology. General Surgery: having 2 sites taking emergency surgery continues to be an issue. All patients were reviewed by a consultant the day of or the day after admission. Surgical ward rounds occur 7 days a week in the morning. Patients admitted between 08.00 and 18.00 get reviewed the following day and therefore do not meet the standard. Plans are in place to move to single site emergency surgery which will impact on the capacity of consultants to conduct a second ward round. Cardiology: in our Clinical Decisiosn Unit (CDU) currently there is not enough cardiology consultant capacity to manage daily cover on the CDU. Funding for further cardiologists has been put in place but the posts are yet to be appointed to. Consultants on Assessment units do have 7 day working in their job plans and Red2Green is in operation in most wards but not all for 7 days.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	All the tests are available on Site over 7 seven days.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	All interventions are available across the Trust	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients requiring 1 review per day - Compliance overall on weekdays was 97% and weekends 87%. Overall across the week compliance was 95%. Patients receiving twice daily review were 100% compliant. Daily Board rounds are in place, 95% of clinical areas are reported to have a ward/board rounds across the Trust Monday to Friday. However this reduces to 59% for Monday to Sunday. There are some gaps in weekend consultant presence in some specialities which to date has not been affordable to rectify.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Patient experience: We differentiate Friends and Family survey question in Assessmnt units. To date this has shown to be high 92-95% with little or no variation between week or week end day admission. Patients, family and carers are consulted at each stage of their care pathway. The Integrated Discharge Team continues to work with clinical teams to promote the 4 key questions in their Clinical areas. • What is the matter with me • What is going to happen today • What is needed to get me home • When am I going home Multidisciplinary team review: The Board and Ward Round Professional standards have been reviewed and updated. They aim to provide guidance to staff about the standards for Board Rounds. Scheduled MDT Board round 5 days a week Monday- Fri AM 52 weeks a year and in some specialities 7 days a week. Shift Handovers: 100% of applicable CMG ward areas (63 wards) are reported to be using the Red2Green principles for highlighting delays in the patient's journey. A new easy view Board Round profile was launched on nerve centre in September 2018 to capture the 'next steps' in the patient's journey. New Policy of clinical Handover is in place - implemented in 2018, Hospital at Night Model is well embedded for handover OOH. Mental Health: A clear 24/7 referral pathway is in place for Emergency Patients. Transfer to community, primary and social care: The Integrated Discharge Team (IDT) is a collaborative service bringing together employees from five Health and Social Care Organisations. There are ward discharge coordinators, 7 day pharmacy, a TTO Project running to improve TTO discharage medication, referral to social services across 7 days, a 7 day Carers Trust Discharge response Team, a small number of Discharge practitioners working 7 days across the emergency floor at LRI Quality improvement; Informatics team provide data on outcomes over 7 Days LOS, Mortality and readmissions. This data is currently being worked on at Service level by day of the week.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Provide a brief summary of issues in cases where not all standards are met.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Annual Fire Report 2018/19

Author: Michael Blair-Interim Head of Compliance (Fire Manager) Sponsor: Darryn Kerr **QOC Paper F**

Executive Summary

Context

The University Hospitals of Leicester (UHL) NHS Trust has a statutory duty to ensure that all of the premises owned and operated by the Trust comply with current Fire Safety legislation and Department of Health guidance on Fire Safety.

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

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

Questions

1. What is the current status of the Fire Risk Assessment programme?
2. Is the Fire Safety Training provided fit for purpose and relevant to Risk?
3. Aside from prioritising and addressing backlog Fire Safety issues what areas of improvement have been identified and included in the work plan for the year 2019/20?

Conclusion

1. The Fire Risk Assessment register continues to show high levels of compliance.
2. The Fire Safety Team continues to provide the required capacity for all staff to complete 'Face to Face' Annual Fire Safety. Fire Training compliance has risen significantly to 87% and we are confident of continuing with this upturn. In addition specific evacuation training and Fire Warden training uptake continues to improve.
3. There are a number of areas that are to be focused on in the coming year within the Fire Safety Team including the priority to recruit and retain competent fire safety advisors to continue to drive improvements across the Trust such as:

I. Improved recording and reporting of all Fire Signals by Switchboard including the reduction of recorded "unknown" causations;
II. Implementation of the new call-out procedure at the LRI;
III. Improvement of documented local evacuation procedures;
IV. Increasing competency through additional, specific training;
V. Development of new training presentations for the varied training sessions provided: Induction / Annual / Volunteer.
VI. Maintain the Fire Risk Assessment schedule to ensure compliance

Input Sought

We would welcome the board's input regarding the content of the report and to recognise the progress being made in relation to Fire Safety across the Trust. We would also request that report is endorsed to enable the annual fire statement to be signed.

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	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[No]
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	[Yes /No /Not applicable]
Board Assurance Framework	[Yes /No /Not applicable]

3. Related **Patient and Public Involvement** actions taken, or to be taken: [Not applicable]

4. Results of any **Equality Impact Assessment**, relating to this matter: [Not applicable]

5. Scheduled date for the **next paper** on this topic: [December 2019]

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

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

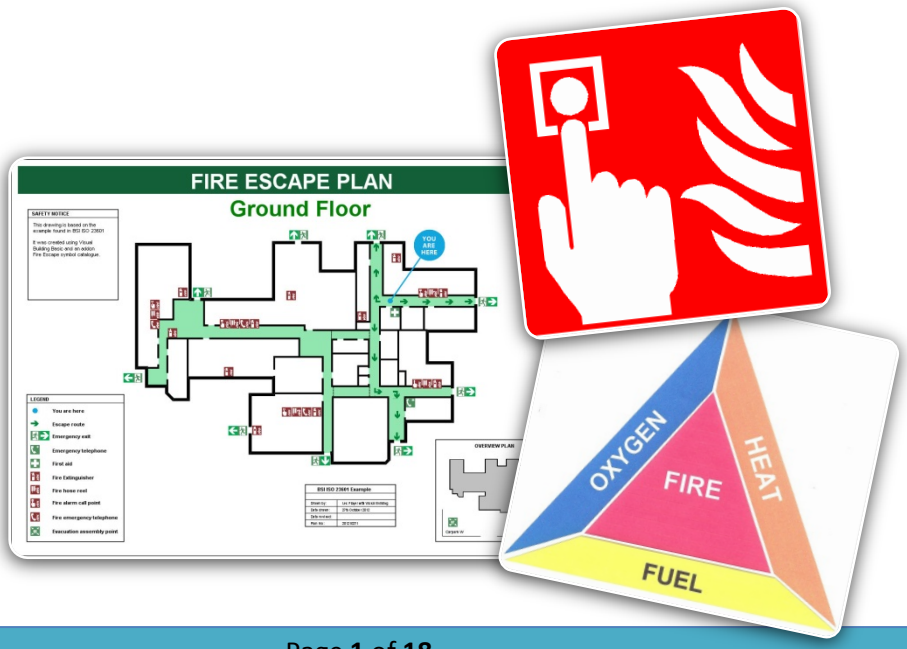
University Hospitals of Leicester
NHS Trust

Caring at its best

Annual Fire Report

University Hospitals of Leicester
2018/19

University Hospitals of Leicester NHS Trust
Michael Blair – Interim Head of Compliance (Fire Manager)



Contents

1.0 Introduction

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

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

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

2.0 Executive summary

2.1 The Reporting Period 2018/19 has seen a consolidation of the Fire Safety services provided by the Trust; the Fire Safety Team has managed to maintain a high level of compliance in regards to Fire Risk Assessments (FRA) and Annual Fire Training.

2.2 The Fire Risk Assessment (FRA) register continues to show high levels of compliance. A total of 194 FRA's were undertaken in the reporting period; these were a mixture of new FRA's and FRA Reviews.

2.3 The Fire Safety Team developed a new compact Fire Risk Assessment template for small areas / single office use. The template is vastly reduced in size but is more suitable and sufficient for the areas concerned.

2.4 The Fire Safety Team continue to provide the required capacity for all staff to complete 'Face to Face' Annual Fire Safety Training however; due to the limitations on resources and difficulty in staff being released from work to attend, we have permitted the E-Learning session to be available to all staff. E-Learning will continue to be available to all in the new reporting period and we will continue to monitor this as an aid to those unable to attend.

2.5 Fire Training compliance has risen significantly to 87% and we are confident of continuing with this upturn.

2.6 Fire Warden Training has continued to progress; we have increased the course attendance size and have now trained 274 Fire Wardens across the Trust. We are hopeful of the continued good attendance on the course.

2.7 The new call out procedure for the Switchboard in relation to fire calls at the LRI has been finalised; training for Switchboard Staff and the Fire Response Teams will be provided in May 2019 with the procedure becoming 'live' on 4 June 2019.

2.8 A significant amount of time has been provided to Capital Projects over the reporting period; including advice and instruction on numerous design drawings for new build

works and large refurbishments. The majority of the input provided has been on the ITU Extension (GH), Interventional Radiology Scheme (GH), Roof Top Modular Wards (GH), Mansion House Refurbishment and EMCHC Scheme at the LRI.

2.9 Leicestershire Fire & Rescue Service has made 10 visits to the Trust; two of these visits were to carryout full Audits of the Glenfield Hospital and the Kensington Building. Both visits were very positive and we were found to be “Broadly Compliant” meaning no major risk issues identified.

2.10 There were 4 reported fires within the reporting period. The fires were minor in nature however; the overheating motor in the Kensington Building generated a full Pre Determined Attendance from the Fire Service as the smoke travelled the full height of the service riser it is located within. The building was subject to the evacuation of non-essential persons while a number of the inpatient areas were subject to horizontal phase evacuation.

3.0 Fire Safety Committee

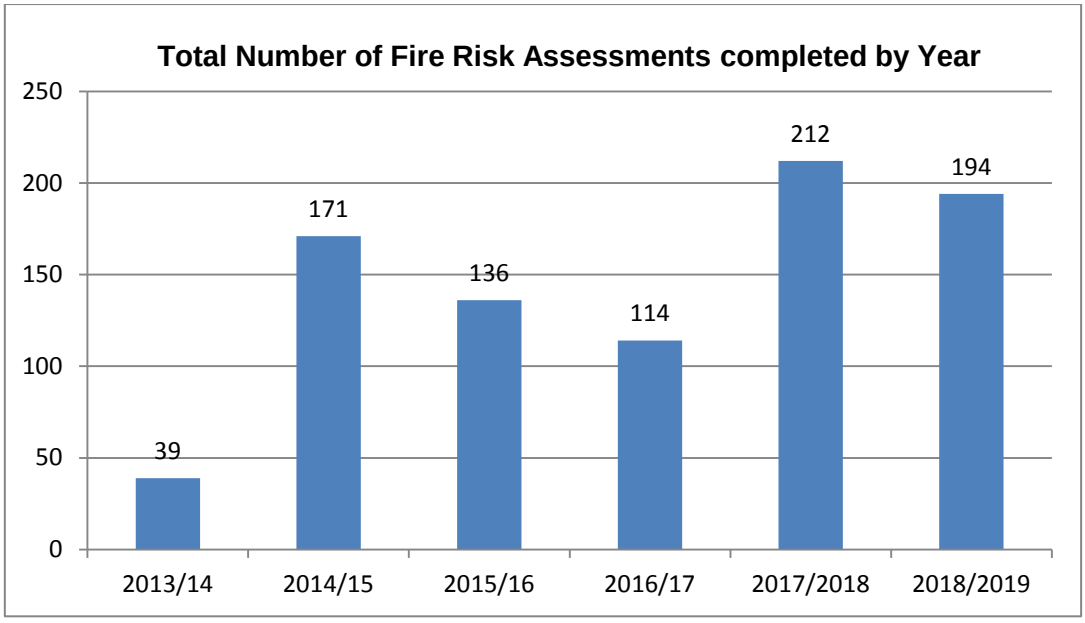
3.1 The UHL Fire Safety Committee continues to act as a subcommittee to the UHL Health and Safety Committee chaired by the Director of Safety and Risk for the Trust. The meetings which are now chaired by UHL’s Head of Compliance are planned quarterly to enable any issues raised to be escalated to the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

4.0 Fire Risk Assessment (FRA)

4.1 In the reporting period 2018/2019 a total 194 Fire Risk Assessments (FRAs) were undertaken and completed across the three acute sites

4.2 The total number of FRAs highlights an 8% decrease in FRAs compared to last year (2017/2018). This can partially be attributed to a decrease in resources due to resignation and long term sickness. During the reporting period the Fire Safety Team have implemented a new Fire Risk Assessment for single use offices in order to risk assess areas which previously did not have a risk assessment.

4.3 Chart 01: Fire Risk Assessments completed

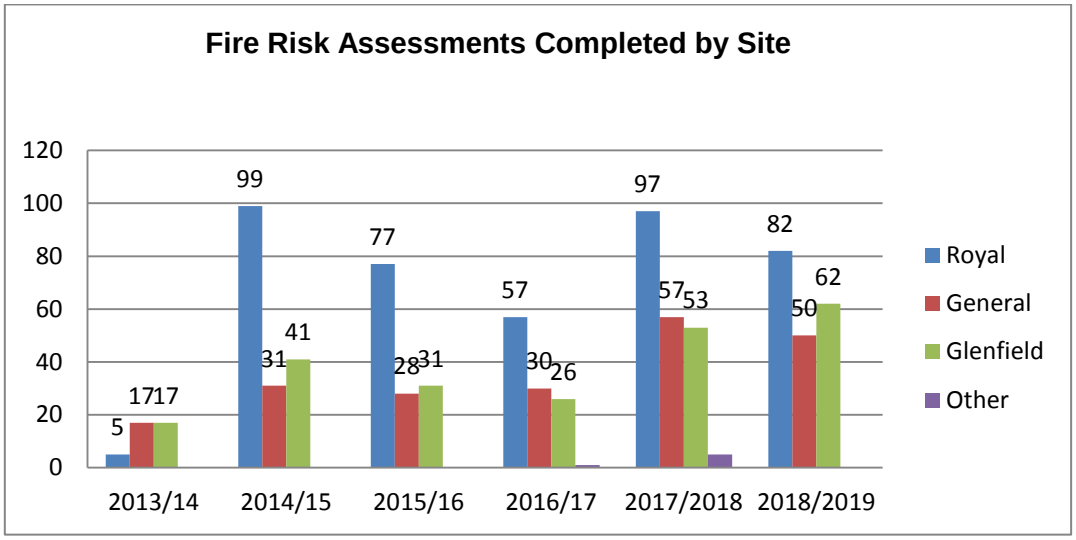


4.4 The graph above demonstrates the progress that has been made in relation to the completion of FRA's since 2014.

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

4.6 Chart 02 illustrates the distribution in workload across the Trust sites with respect to Fire Risk Assessments. The FRA's at the LGH and Glenfield sites have risen significantly since 2014; the FRA's at the LRI have levelled out due to compliance and the current Risk Assessment Review periods.

4.7 **Chart 02**



5.0 Common Themes Fire Risk Assessments

5.1 Analysis of the Fire Risk Assessment findings has identified that there are a number of common themes being reported by the Fire Safety team. Examples of which are listed below:

a) Fire resisting door sets; damaged heat and smoke seals/failing to close into frame/insufficient fire resisting potential. This will be a continual theme due to the nature of the work place and the high volume of transit through these door sets.
b) Fire resisting doors into hazard rooms wedged or propped open. This issue is addressed with Local Management at the time of the assessments however; it is difficult to manage due to the role of specific hazard rooms and climatic changes, specifically during the summer months.
c) The lack of Fire Alarm mimic panels within specific areas; Glenfield / Windsor Building /Kensington / Balmoral Level 2. This is to be addressed when new Fire Alarm Systems are installed or significant refurbishment work is carried out which involves changes to the current fire alarm 'make up' within those Departments.
d) Departments with no Fire Wardens and not carrying out monthly Local Fire Safety inspections. This is improving due to the on-going Fire Warden courses however; we have increased the course size in an attempt to ensure that the issue continues to progress.
e) No suitable Emergency Evacuation Plans. This has also improved as awareness is raised into the requirement however; we are now progressing with improving the content of these plans. This is carried out during Fire Warden Training and the Annual Fire Safety sessions.
f) Storage and waste located within the Means of Escape (MOE). We address this issue during Annual Fire Safety Training and also attend all concerns where staff have been unable to rectify potential issues.
g) Change of use to rooms that have now become Hazard Rooms without a change to the structure, dampers and Automatic Fire Detection (AFD). We are working more proactively with the Project Teams to address these issues prior to the change of use occurring.

5.2 These examples are provided for illustrative purposes and should be taken in context with the significant volume of items collated as part of the risk assessments over what is a comprehensive and vast Estate.

5.3 All backlog maintenance and capital investment works are identified as part of the FRA process and forwarded to the relevant departments to plan, cost and rectify any compliance issues. All deficiencies are assessed on a 'risk to compliance/cost basis'.

5.4 The Fire Safety and Capital Projects teams meet regularly to assess the risks identified and prioritise work streams for the current and subsequent financial years; quarterly Risk Prioritisation Meetings have taken place throughout the reporting period.

5.5 Concerns raised at a local management level continue to sit with the identified responsible person at ward level to ensure adherence to policy and legislation. Where necessary assistance is provided by the Fire Safety Team.

5.6 Any identified risks considered significant are also logged on the Estates and Facilities Risk Register via the Senior Management Team and where required

onwards to Executive Meetings and/or Trust Board for consideration in line with established governance arrangements. The Trust Health and Safety Committee are also advised of any such risks via the output of the Fire Safety Committee

5.7 Regular review of the Risk Assessment findings is also used to drive the current work plan.

6.0 Capital works

6.1 The Fire Safety Team is actively engaged in determining the priorities for the Estates and Facilities capital programme. They use their local knowledge to compliment the fire risk assessments and action plan data to set the programme of works balanced against available capital.

6.2 Table 01 is a brief outline of the Capital Projects that the Fire Safety Team were actively engaged in supporting during 2018/19; in some cases these schemes continue into the 2019/20 Capital programme.

6.3 Table 01

Site	Building/Department	Open/Closed
LRI	New Emergency Department Phase 2	Completed in June 2018.
LRI	EMCHC (Kensington Building)	Assistance provided through the design stage and this is still on-going; projected start date of January 2020.
LRI	Ward 15 & 16 Refurbishment	Assistance provided throughout the design stage and in regards to the installation of a new fire alarm system. Expected completion date of June 2019.
GH	New Interventional Radiology (IR) Scheme	Planning stage only; Initial plans have been signed off in regards to design and work is due to begin during the summer of 2019.
GH	Roof Top Modular Wards	The design was signed off and enabling works are to begin at the start of the 2019/20 financial year.
GH	ITU Extension and Refurbishment Works	The design was signed off and enabling works are to begin in April 2019.
GH	Mansion House Refurbishment	All design drawings signed off and the work is due to be completed in May 2019 with occupation to take place immediately on completion of works.
GH	New Decontamination Building	Assistance provided through the design stage and drawings signed off in principal. No start date yet provided for the start of works.
GH	New Ward 20 (Winter Pressure Ward)	Assistance provided through the design and construction stages; completed and occupied in January 2019.
GH	CDU expansion into the old Ward 20	Assistance and advice provided into the Ward expansion; completed in January 2019.

LGH	New Decontamination Unit	Advice provided in regards to safe locating of the unit. Building in place but not yet occupied.

6.4 In addition to the above and working closely with the Capital Project Team a number of additional projects were undertaken:

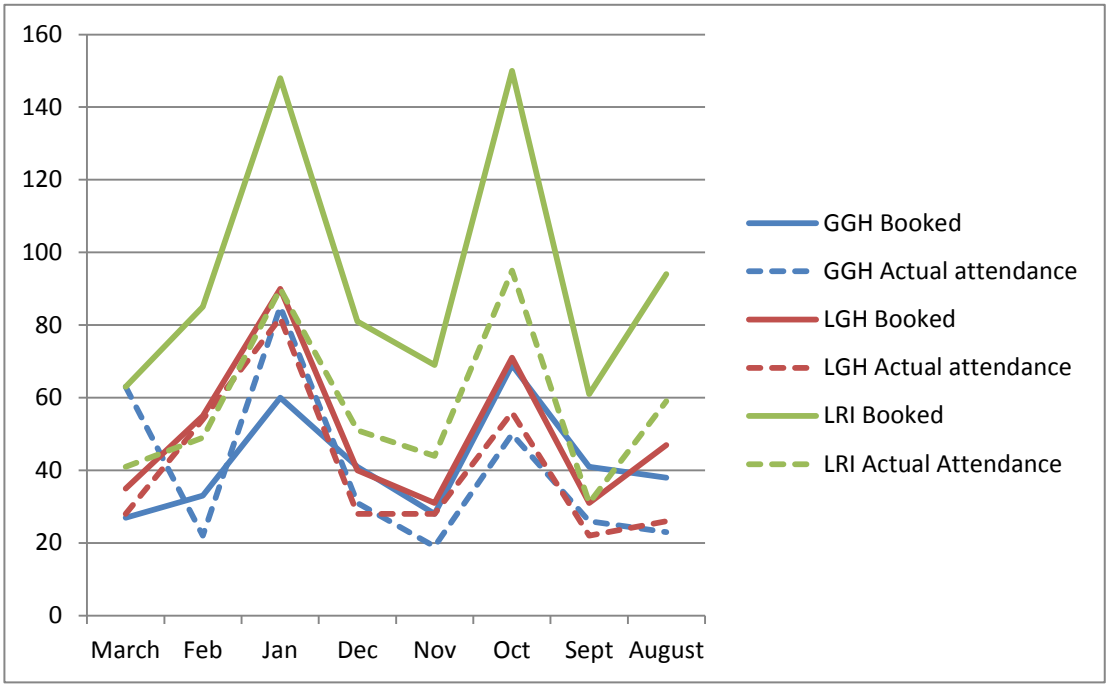
a) Compartment Survey of the Windsor Building; this was carried out in preparation for the installation of a new Fire Alarm System to meet L1 compliant standard.
b) Fire Alarm Upgrades of Glenfield Residencies; this has continued from the previous financial year and was part of the planned Capital Projects work resulting from the prioritisation meetings held by the Capital Team.

6.5 Projected constraints on Capital expenditure for the year 2019/20 have the potential to impact on addressing the Fire Safety priorities identified as they compete with other statutory requirements and the backlog programme particularly if moving between allocations becomes necessary in year. However, the programme as currently defined, provides a significant capital allocation for 2019/20 to address current priorities and some historical shortfalls.

6.6 It is expected that 2019/20 will be a busy year in regards to Capital Works; there are three very large schemes taking place at the Glenfield site and the EMCHC Scheme will take up significant time and planning for the Fire Safety Team due to the nature of the works.

7.0 Training

7.1 Chart 03



7.2 Chart 03 illustrates actual attendance at Face to Face Fire Safety Training sessions vs booked places. During 2018/2019 there has been a decline in the uptake of face to face sessions due to e-learning being opened up to all members of staff.

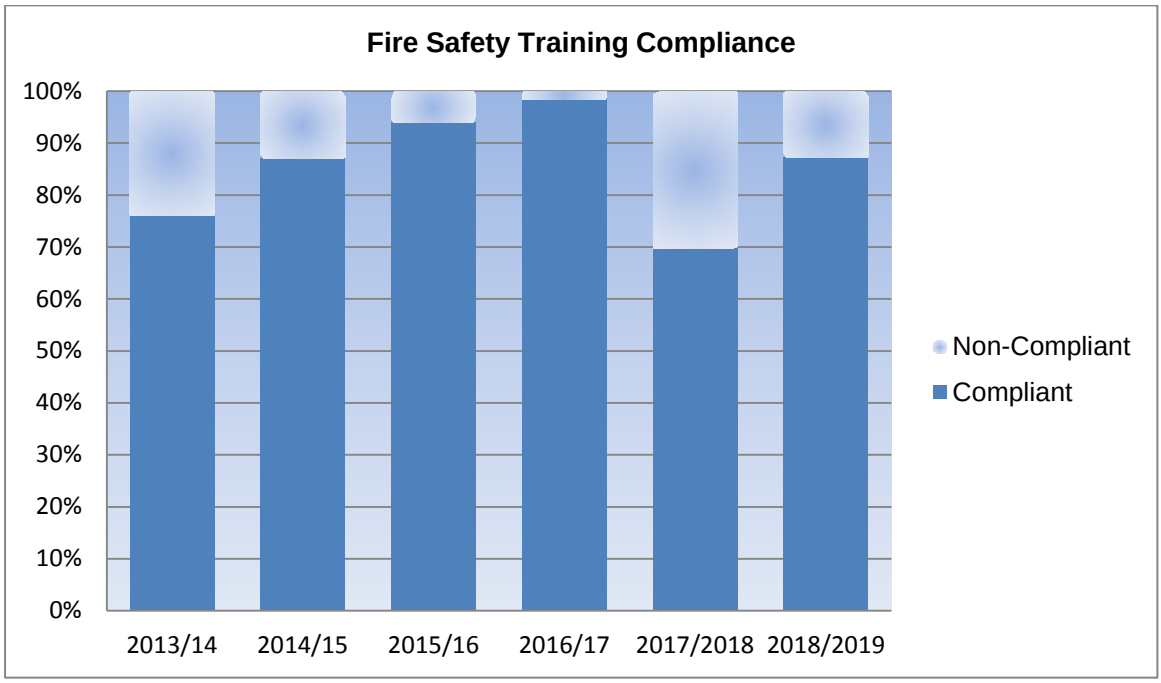
7.3 Adequate fire safety training is essential to ensure that fire prevention and emergency action plans can be put into practice. The provision of adequate fire safety training is a legal duty placed upon the Trust and therefore forms part of the Mandatory suite of training hosted by HELM. It follows therefore that there should be 100% compliance.

7.4 At the time of writing this report reporting figures on HELM show compliancy for Fire Safety Training at 87%. It should be noted that this figure includes 669 bank staff members who have not completed Fire Safety training and therefore are unable to work for the Trust. If this group of staff are omitted from the figures, compliancy increases to 91%.

7.5 In order to address the shortfall in the uptake of Fire Training; the Fire Safety Team will provide three extra courses during the Festival of Learning in June 2019.

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

7.7 Chart 04



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

a) Fire Safety Induction (Corporate)
b) Fire Safety Induction (Local)
c) General Fire Safety – Face to Face (lecture theatre / CMG Training) days
d) General Fire Safety – e-learning

7.9 A total of 180 CMG Fire Training sessions have been supported throughout the year by the Fire Safety Team.

7.10 A total number of 278 Fire Wardens have been trained; the training has been well received and all future sessions are available to book via HELM.

7.11 Currently there is no practical fire extinguisher training programme in place. The use of fire extinguishers is covered in all training courses but is limited to visual and verbal instruction. Fire Safety Team has investigated the possibility of delivering practical training to fire wardens using fire extinguisher simulation equipment. We are hoping to progress this during the next reporting period and are requesting funding to purchase the equipment.

8.0 Unwanted Fire Signals (UwFS)

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

8.2 Whilst all reasonable means of minimising UwFS should be employed, it is recognised that the complete elimination of UwFS is impossible but every attempt should be made to identify common themes and undertake causal analysis in order to reduce the frequency year on year.

8.3 An organisation's UwFS rate will be influenced by a variety of factors, including the building size and the number of detectors/call-points, the activities carried out within the building, the building location, and its management.

8.4 The main influence on the rate of UwFS generated by a system is likely to be the number of automatic detectors connected to that system however; with large complex sites it is possible that more than one system may be installed. The age of the Fire Alarm System is also to be considered when reviewing UwFS figures. Due to the nature of a Fire Alarm System, elements require updating and replacing to reduce the risk of UwFS; without this capital investment the Fire Alarm System is at a higher risk of failure.

8.5 Unwanted fire signals should be categorised in order to identify their causes, record and report their occurrence, and allow appropriate actions to be decided on for their reduction. Following any UwFS an investigation should take place to identify the cause. The table below shows the distribution of UwFS across all 3 sites with the LRI being responsible for returning the highest number of UwFS across the Trust.

8.6 The total UwFS across the UHL sites in this reporting period totalled 211 with the highest percentage originating from the LRI site. It is however worth relating this figure to the number of detectors (c.6000) located at this site. This is a 22% increase based on 2017/18's data.

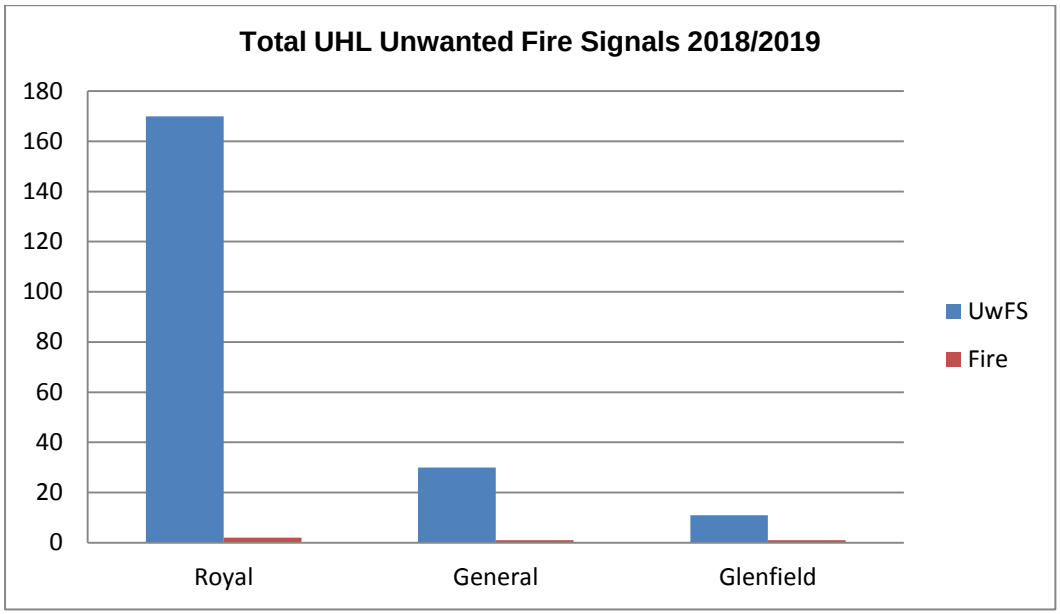
8.7 A new procedure for UwFS call handling has been developed, a paper was presented at the Health & Safety committee where it was supported fully and recommendation given that a presentation be prepared and presented to the EQB. The EQB gave the 'go ahead' for the new procedure this was started on 4 June 2019. The training for the Fire Response Teams and confirmation exercises took place in May 2019. It should be noted that the new procedure is for the LRI only as the staff make up in regards to the LGH and Glenfield does not support the procedure change at this time.

8.8 The new procedure involves the implementation of a 5 minute delay in Switchboard making the '999' call to the Fire Service for Fire Alarm activations; this will allow for a suitable investigation to take place. It should be noted that an immediate '999' call will be made if Fire or Smoke is identified at any time and confirmed via a '2222' call to Switchboard. The only exception is if a fire alarm is activated in a Service Area or Plant Room; on these occasions, an immediate '999' call will be made by Switchboard.

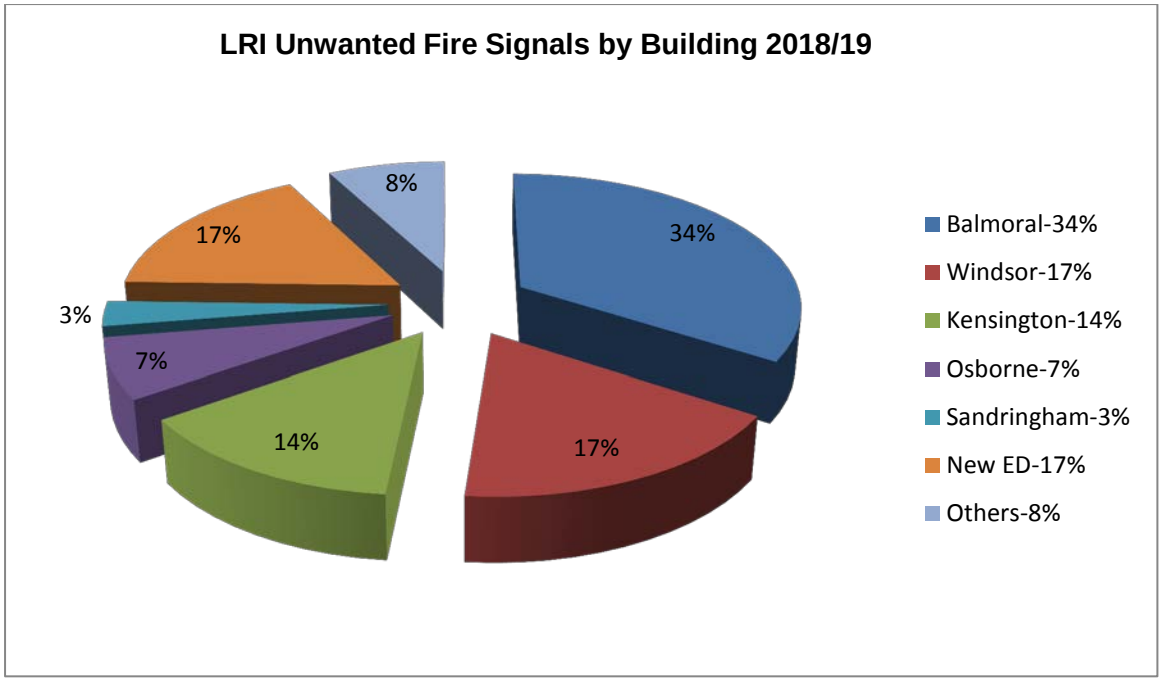
8.9 The new procedure is a method of managing our UwFS however; the aim is to use the technology of current Fire Alarm Systems to manage the issue when we install them across all three sites. The new Fire Alarm System in the Windsor Building will provide this technology.

8.10 Chart 05 indicates that there were four actual fires recorded within the reporting period; the fires are identified within Section 10 of this report.

8.11 Chart 05

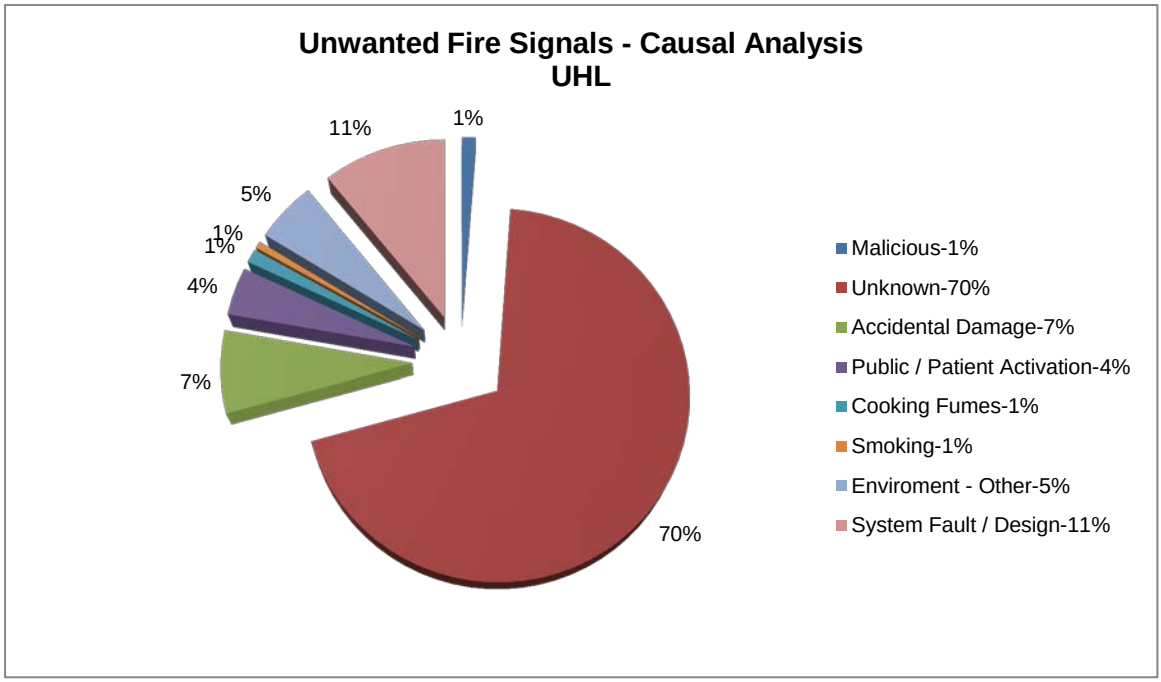


8.12 Looking at more detail in the figures obtained for the LRI we can see that the greatest instances of UwFS emanate from the Balmoral building equating to 34% of the total reported.



8.13 Chart 06 illustrates that there are common themes in general and across the 3 sites individually. Work is currently underway to improve reporting of these events to ensure they are correctly categorised in line with Department of Health guidance (HTM 05-03) and reduce those classified as "unknown" to a minimum to provide a more reflective and useful data set.

8.14 Chart 06 – Unwanted Fire Signals Causation



8.15 The fire safety team have developed an improved recording and monitoring system to ensure consistency of what is recorded and how each alarm activation is classified however; as the figures show, we are still lacking in detail regards causation. This is

currently being addressed with Switchboard staff and we believe the implementation of the new call out procedure will assist with identifying causes.

8.16 Once the data set is robust enough more accurate statistics can be produced and actions implemented to target specific areas.

8.17 This will be in line with the reduction criteria set out in HTM 05-03 part H "Reducing false alarms in healthcare premises".

8.18 To support the new documentation to record these events; the focus is on education via the revitalised Fire Safety Training the introduction of Fire Warden training and ensuring that investigations are completed and findings communicated through the appropriate channels.

9.0 Fires

9.1 There have been four fires within the reporting period:

a) Leicester General Hospital – Catering Department – 20th April 2018 at 06:30
   - Tin foil used for cooking and left on a hot plate.

b) Leicester Royal Infirmary – Kensington Building – 4th May 2018 at 11:41
   - Overheating motor in basement resulted in full building evacuation of non-essential staff and horizontal phase evacuation of inpatient areas affected. The smoke from the motor transited the full height of the service riser it is located within which resulted in a full Pre Determined Attendance (PDA) from the Fire Service.

c) Leicester Royal Infirmary – Assisted Conception Unit – 10th May 2018 at 11:30
   - Faulty light fitting fire causing full Fire Service Attendance due to difficulties in the investigation of the fire.

d) Glenfield Hospital – Ward 25 – 2nd April 2018 at 09:45
   - Small Toaster Fire.

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

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

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

10.0 Freedom of information requests

10.1 There were no Freedom of Information requests for the reporting period 2018/19.

11.0 Enforcement

11.1 No Enforcement notices were issued to the Trust in the reporting period.

11.2 Leicestershire Fire and Rescue Service have conducted 10 visits across all three sites; these are listed below. Two of the visits were to carry out Full Audits of either a site or building.

a) Quarter 1 – GH – Full Audit of Main Building
b) Quarter 1 – LRI – Osborne and Windsor Buildings Risk Visit
c) Quarter 1 – LGH – Main Building Risk Visit and Familiarisation
d) Quarter 1 – LRI – UwFS Meeting
e) Quarter 1 – LGH – UwFS Meeting
f) Quarter 2 – LRI – Full Audit of Kensington Building
g) Quarter 3 – GH – Audit of Dry Risers
h) Quarter 3 – LRI – Familiarisation Meeting
i) Quarter 4 – GH – Site Access and Capital Works Visit
j) Quarter 4 – GH – Site Access and Capital Works Visit

11.3 The Full Audits of the Glenfield Hospital and Kensington Building were found to be 'Broadly Compliant' meaning no high risk issues identified and with no further action required.

11.4 Due to the high volume of Capital Works taking place at the Glenfield Hospital; we have opened lines of communication with the Fire Service to ensure that access for appliances is maintained at all times.

12.0 Estates Return Information Collection (ERIC)

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

12.2 The ERIC data relating to Fire Safety for 2018/19 has been submitted as outlined below:

12.3 Table 02 UHL ERIC Return for FIRE 2018/19

Ref	Field	Definition	Unit(s)
01	Fires recorded	Total number of fires recorded as required by HTM 05-01: Managing healthcare fire safety. https://www.gov.uk/government/publications/managing-healthcare-fire-safety	4
02	False alarms – No call out	Total number of false alarms that were dealt with by the organisation, without the fire and rescue service being called out.	113
03	False alarms – Call out	Total number of fire alarms that were attended by the fire and rescue service, but which the cause was a false alarm.	108
04	Number of deaths resulting from fire(s)	Total number of deaths of patients, visitors and staff resulting from fire(s).	0
05	Number of people injured resulting from fire(s)	Total number of patients, visitors and staff injured resulting from fire(s).	0
06	Number of patients sustaining injuries during evacuation	Total number of patients injured during evacuations, caused by fires or false alarms.	0

13.0 Fire Safety Resources

13.1 The Fire Safety Team currently employs three Fire Safety Advisors equating to two and a half full-time equivalent posts. There are currently two vacancies one of which one is being covered by a full time Contractor. There has been a successful re-banding exercise with the positions now being banded at band 7, vacancies have been advertised and the recruitment process is to be completed during Quarter 1 2019.

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

13.3 UHL are supported by two full-time Fire Safety Advisors

13.4 LPT and NHS PS were supported by two part-time Fire Safety Advisors

14.0 Fire Safety Work Plan / Priorities for 2019/20

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

a) Improved recording and reporting of all Fire Signals by Switchboard including the reduction of recorded “unknown” causations as illustrated in Chart 06.
b) Reduction of UwFS across all 3 acute sites and the implementation of the new call-out procedure at the LRI.
c) Development and improvement of documented local evacuation procedures.
d) Continue to increase the number of suitably training Fire Wardens across the Trust.
e) Continuation of the development and implementation of local Fire Log books.
f) Development of new training presentations for the varied training sessions provided: Induction / Annual / Volunteer.
g) Maintain the Fire Risk Assessment schedule to ensure compliance.

14.2 The Backlog Capital plan for 2019/20 remains fluid and dependent on what final budget allocation is received, but the following works have been identified as priority:

a) Fire Alarm System upgrades for the Balmoral Building and the Residencies at the Glenfield.
b) Compartmentation to the Hospital Streets at the Glenfield site (Phase 1); this includes fire resisting door sets.
c) Fire Door replacement for non-compliant door sets onto the Hospital Streets at LGH.
d) Fire Alarm System upgrade at the LGH.
e) Increased Fire Detection in LGH Main Theatres.
f) Compartmentation across three sites.

15.0 Appendix A – Annual Fire Statement

Annual Fire Safety Statement: 2018/19

NHS Organisation: University Hospitals of Leicester NHS Trust (UHL)
I confirm that for the period 1 April 2018 to 31 March 2019, all premises which the organisations owns, occupies or manages have had Fire Risk Assessments undertaken in compliance with the Regulatory Reform (Fire Safety) Order 2005, and (please 'check' the appropriate boxes)

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

Chief Executive:	John Adler
Signature:	
Date:	

Director of Estates and Facilities:	Darryn Kerr
Signature:	
Date	

Fire Safety Manager:	Michael Blair
Signature:	MBlair
Date:	21 May 2019
Completed Statement to be retained for future audit.	

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

CQC Statement of Purpose

Author: Helen Harrison, CQC Project Manager
Sponsor: Carolyn Fox, Chief Nurse

QOC Paper G

1. Context

1.1 The CQC define a Statement of Purpose as "a legally required document that includes a standard set of information about a provider's service".

1.2 At the quarterly CQC Provider Engagement Meeting held in June 2018, our Inspection Manager requested that we complete a review of the locations listed on our Statement of Purpose, in line with the CQC's guidance - *"What is a 'location'? Guidance for providers and inspectors".* This guidance is attached as Appendix A.

1.3 This review, which has been carried out in conjunction with The Alliance Clinical Director and The Alliance Manager and Alliance Head of Nursing has focused largely on those locations from which activity under the UHL pillar of The Alliance is undertaken.

1.4 The recommendation from this review is that the following locations should be re-classified on UHL's Statement of Purpose as satellite outpatient clinics in accordance with Rule 8(a) of the CQC's guidance - *What is a 'location'? Guidance for providers and inspectors":*

- Rutland Memorial Hospital
- Feilding Palmer Hospital
- Coalville Hospital

2. Recommendations

2.1 QOC is asked to:

a) Approve the reclassification of Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital as satellite outpatient clinics under Rule 8(a) of the CQC's guidance - *What is a 'location'? Guidance for providers and inspectors*

b) Approve the registration of Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital under the Trust's headquarters, the Leicester Royal Infirmary

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	[Yes]
Consistently meeting national access standards	[Yes]
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:

   a. Organisational Risk Register [N/A]
   b. Board Assurance Framework [Yes]

3. Related **Patient and Public Involvement** actions taken, or to be taken: [N/A]

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

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

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Quality and Outcomes Committee

DATE: 27 June 2019

REPORT BY: Helen Harrison, CQC Project Manager

SUBJECT: CQC Statement of Purpose

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1. Background

1.1 This paper sets out proposed changes to the Trust's Statement of Purpose

2. What is a statement of purpose?

2.1.1 The CQC define a Statement of Purpose as "a legally required document that includes a standard set of information about a provider's service".

2.1.2 The Statement of Purpose must describe:

- A provider's aims and objectives in providing the service
- Details of the services provided including the service types (for example, hospice services) and the service user bands (for example, adults aged 65+)
- The health or care needs the service sets out to meet
- A provider's and any registered managers' full name(s), business address(es), telephone number(s) and (where available) email address(es)
- Details about the legal status of the provider (for example, whether they are an individual, company, charity, or partnership)
- The address CQC must use to send formal documents to registered providers and managers. Formal documents include legally required notices and inspection reports. ('Addresses for service' can be email addresses where a provider or manager consents to receiving documents in this way)
- All of the locations where regulated activities are actually provided, or where they are provided from (listed as 'locations' on your certificate of registration together with any service branches not listed as locations). The information in statements of purpose must always be accurate and up to date

2.1.3 The CQC provide a four part template for the purpose of articulating the above. UHL's Statement of Purpose adheres to the format set out in this template.

3. When is a Statement of Purpose required?

3.1 A Statement of Purpose must be submitted to the CQC in two sets of circumstances:

- When first applying for registration
- When any of the information contained in the Statement of Purpose changes

3.2 The locations currently registered with the CQC (included on our Statement of Purpose) are:

- Glenfield Hospital
- Leicester Royal Infirmary
- Lincoln Renal Unit
- Dr Chandra Mistry Haemodialysis Unit
- Northampton Renal & Dialysis Unit
- Kettering Renal Unit
- Peterborough Renal Unit
- Feilding Palmer Hospital
- Coalville Hospital
- Hinckley & District Hospital & Hinckley Health Centre
- Loughborough Hospital
- Melton Mowbray Hospital
- Rutland Memorial Hospital
- St Lukes Treatment Centre / Endoscopy Suite
- St Marys Birth Centre
- National Centre for Sports and Exercise Medicine

3.3 This means that any or all of these locations could be inspected either as part of a comprehensive inspection, a core service with well-led inspection or a focused inspection.

4. Review of UHL's Statement of Purpose

4.1 At the quarterly CQC Provider Engagement Meeting held in June 2018, our Inspection Manager requested that we complete a review of the locations listed on our Statement of Purpose, in line with the CQC's guidance - *"What is a 'location'? Guidance for providers and inspectors".* This guidance is attached as Appendix A.

4.2 This review, which has been carried out in conjunction with The Alliance Clinical Director and The Alliance Manager and Alliance Head of Nursing has focused largely on those locations from which activity under the UHL pillar of The Alliance is undertaken, i.e.:

- Feilding Palmer Hospital
- Coalville Hospital
- Hinckley & District Hospital & Hinckley Health Centre
- Loughborough Hospital
- Melton Mowbray Hospital
- Rutland Memorial Hospital
- St Lukes Treatment Centre / Endoscopy Suite

5. Recommendation from the review

5.1 The recommendation from this review is that the following locations should be re-classified on UHL's Statement of Purpose as satellite outpatient clinics in accordance with Rule 8(a) of the CQC's guidance - *What is a 'location'? Guidance for providers and inspectors":*

- Rutland Memorial Hospital
- Feilding Palmer Hospital
- Coalville Hospital

5.2 The example for a location falling under Rule 8(a) given by the CQC in their guidance is as follows:

"A satellite outpatient clinic that serves an acute hospital, but that does not fall into any of the rules 1 to 7 in its own right. Where this is the case, the clinic can be included as part of the service provider's registration at the location of the acute hospital, regardless of geographical location. Where that outpatient clinic serves more than one acute hospital location, **the service provider can decide at which of its other locations it is most appropriate for the clinic's services to be included".**

5.3 It is therefore proposed that Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital are registered under the Trust headquarters, the Leicester Royal Infirmary.

5.4 It should be noted that if it is the case that services are managed from a main location and do not satisfy any of the rules 1 - 7, the provider still needs to ensure that the requirements of regulations are being met in the provision of activity.

5.5 An updated copy of the Trust's Statement of Purpose, reflecting the re-classification of Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital as satellite outpatient clinics under Rule 8(a) and registered under the Trust headquarters, the Leicester Royal Infirmary is attached as Appendix B.

6. Recommendations

6.1 QOC is asked to:

a) Approve the reclassification of Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital as satellite outpatient clinics under Rule 8(a) of the CQC's guidance - *What is a 'location'? Guidance for providers and inspectors*

b) Approve the registration of Rutland Memorial Hospital, Feilding Palmer Hospital and Coalville Hospital under the Trust's headquarters, the Leicester Royal Infirmary

What is a ‘location’?

Guidance for providers and inspectors

February 2016

Introduction

In your application for registration, you will be asked to declare that you will comply with all the fundamental standards – the standards below which care must never fall, for each regulated activity you provide at each location. We will monitor compliance against this declaration as part of our decisions about your registration status.

Locations will be listed as 'restrictive conditions' on your certificate of registration, and it is therefore necessary to define locations in a consistent and proportionate way. Also, you will be required to set out, in your statement of purpose, the locations at which the regulated activities are carried on.

This guidance document sets out the rules for identifying your locations. It supersedes all previous guidance about locations.

What is a location?

A location is:

1. A place to which people are admitted to for the purpose of receiving a regulated activity, or
2. A place in which people live as their main or sole place of residence or in which they are educated, and they receive care or treatment there, or
3. A walk-in centre, or
4. A primary medical, primary dental or out-of-hours service, or
5. The branch of an agency providing care, or
6. A regional headquarters from which a national or cross-regional independent ambulance service is managed, or
7. A stand alone purpose-built diagnostic or screening facility.

If none of these apply, than a location is also:

8. A place where regulated activities are managed from.

There are some additional rules that cover specific scenarios.

A location is <u>not</u> the private address of a person who uses services.

The Care Standards Act 2000 required registered providers of adult social care and independent healthcare services to register these services at the level of each "establishment" or "agency". This meant, for example, that each individual care home, acute hospital, clinic or branch of an agency was identified as the place in which registerable services were provided. It is anticipated that the majority of those establishments or agencies will form the locations required for the purposes of registration under the Health and Social Care Act 2008. However, while that will be the case in most circumstances, particularly regarding establishments, providers should carefully read the following guidance to make sure that they are correctly identifying locations against the rules below.

Identifying your locations

To identify all your locations, you should work through the rules in the order they appear.

For most providers, their locations will come within rules 1 to 8. There are also rules applying to the following specific circumstances:

- Where partnership, jointly funded, integrated care or other arrangements are in place and where services are carried on between or on behalf of service providers in a range of places (rule 9).
- Emergency remote clinical advice and triage (rule 10).
- NHS trusts providing care home or domiciliary care services (rule 11).

Rule 1

A location is: A place to which people are admitted for the purpose of receiving a regulated activity

a) For the purposes of defining locations, CQC considers people to be admitted where the place is not their main or sole place of residence, and either:

- They stay overnight within that place, or within a defined area of that place (such as a prison hospital wing), for the specific purpose of receiving the regulated activity; or
- Beds, trolleys, couches or reclining chairs are provided for the purpose of their post-procedural recovery from procedures delivered in an operating theatre, dialysis room, endoscopy room or treatment room (other than within a GP or dentist's surgery – see 4 below, or in a consulting room – see 4 below); or
- They are detained there under the Mental Health Act 1983, other than under a section 135 or 136.

b) The criteria above will apply to a range of types of services including, but not restricted to, acute hospitals, community hospitals, mental health hospitals, day surgery hospitals, and stand-alone dialysis or endoscopy services.

In some cases, particularly acute hospital services, the place from which they are operating may comprise a group of buildings from which regulated activities are provided. The service provider may apply to be registered to carry on the activity, or activities, from the group of buildings as a whole and have that group of buildings regarded as one location. Where this is the case, the registered address for that location will be the postal address for one of the buildings within that group of buildings. The service provider may select which of the buildings it is most logical to give as the address.

Typically, this example may cover a large hospital site, with a number of buildings, which may cover a reasonably large area and be intersected by public and/or private roads, but which would reasonably be recognised as a distinct, single location by people who use its services.

In deciding whether a group of buildings falls into this example, the following considerations will apply. The group of buildings described as a location should not include any building if:

- That building is within a different city, town or postal area* than the chosen address of the group of buildings; or
- That building can only be reached from the main address of the group of buildings by travelling a considerable distance on public roads or footpaths (CQC will not specify what 'a considerable distance' is, but service providers should consider how far a fairly healthy person could reasonably be asked to travel on foot from one part of the group of buildings to another); or
- The building is branded distinctly differently from the main address of the group of buildings, so that it would appear not to be related to it.

Note: A postal area is the first 3 or 4 digits of the postcode e.g. SW1 or NE10.

Rule 2

A location is: A place in which people live as their main or sole place of residence or in which they are educated, and they receive care or treatment there

a) Where a service provider provides accommodation that is bound together with treatment or care to people who regard the place as their home or their main or sole place of residence, then that place will be a location in the following circumstances:

- The person will regard the place as their home because they have a tenancy or contractual agreement in place or a formal contract that gives them rights as a resident of that place and to receiving care or treatment in that place.
- The tenancy or contractual agreement binds together the provision of the accommodation and the provision of the care or treatment.
- Where the tenancy or contractual agreement binds together the accommodation and the care or treatment, but those elements are provided by legally distinct entities, it will be the service provider directly providing the regulated activity that will be required to be registered and who will cite the place as a location.
- Although one or more of the residents may still have a separate privately-owned house(s) outside of the place where they now live, the place where they live and receive

care or treatment is regarded by them, their family and friends as the main place where they now live.

- Where a service provider delivers care to people to whom they are also providing further education*, then the place in which the regulated activity is carried on will be a location.

- For the purposes of this rule, the following types of services are included, but not necessarily limited to:
  - Care homes providing both accommodation and personal care
  - Care homes providing both accommodation and nursing or personal care
  - Substance misuse service where the accommodation is provided along with the treatment
  - Further education establishment providing accommodation with nursing or personal care.

b) This rule does NOT apply where the address is a person's 'private house'. The common indicators that an address is distinct from this rule are:

- The person may have lived at the address for some time before supportive care services were required and supplied.
- The address is either privately-owned by the person or they have a tenancy agreement that does not, in any way, bind together the provision of accommodation with the provision of care or treatment.
- For the purposes of these exceptions, the following types of accommodation are excluded, but not necessarily limited to:
  - A privately-owned home
  - A home rented from a local authority, housing association or private landlord in which the tenancy agreement does not include the provision of care
  - The individual houses where people live under a supported living scheme
  - Extra Care Housing scheme where the accommodation is not provided
  - Lived in care arrangements where the carer lives in the person's private home
  - The individual houses where people live under a shared lives scheme.

c) It could be the case that the place is made up of several buildings grouped closely together. To decide how these groups of buildings should be considered, you should follow the same principles as those set out in 1(b).

* For the purposes of paragraph 4 of Schedule 1 of the Health and Social Care Act (Regulated Activities) Regulations 2010.

For example:

- Single care home A provides a range of services, including personal care, to people with learning disabilities. The care home is the head office and the only care home operated by the service provider; it will be the sole location for the service provider.

- Large care home service provider B provides personal care and support to people who require nursing care. The service provider has 15 care homes in which people have rights of residence which bind together their accommodation and their care. Each of the 15 care homes will be a location.

Rule 3

A location is: A walk-in centre

For a walk-in centre to be defined as a location in its own right, it must be a permanent service, providing one or more regulated activities, from premises that are under the direct control and management of the service provider. The place where this service is carried on is a location.

Where a walk-in centre does not fulfil the criteria set out here, it will not be listed as a separate location but will be included within the service provider's headquarters (HQ) address (refer to rule 8(b) below).

Where other registerable community services are provided within the same premises as a walk-in centre, and where the walk-in centre fulfils the criteria for being a location in its own right, those community services will **not** be included within the walk-in centre's location but will be included within the service provider's HQ address (refer to 8(b) below). This will be the case even though those community services may be operationally managed from a place other than the service provider's HQ.

Detailed guidance about primary medical services and location can be read in our `quick reference guide: GP out of hours

services which can be found on our website.
http://www.cqc.org.uk/content/gp-practices-and-out-hours-service-providers

Rule 4

A location is: A primary medical care service, primary out-of-hours service or primary dental care service

Where a service provider provides a primary medical service, primary out-of-hours service* or primary dental care service carrying on one or more regulated activities, the place in which that service is provided is a location.

Where a GP provider has a main surgery and one or more branch surgeries associated with the main surgery, the branches are not locations as long as only patients from the same registered patient list are seen or treated at these places. If there is a different registered patient list to that of the main surgery, then the branch surgery is a location.

Where other registerable community services are provided within the same premises as a primary medical service, primary out-of-hours service or primary dental care service, those community services will **not** be included within the primary medical service, out-of-hours service or primary dental care service's location but should be considered in the light of rule 8(b) below.

Where two or more providers provide legally distinct primary medical services, primary out-of-hours services or primary dental care services, at the same premises, then each provider should cite the premises as a location.

* For the purposes of this rule, the location is the place from where the primary out-of-hours service is run, the place from where calls are received and healthcare professionals are dispatched and controlled, or where some patients are asked to attend in order to see a health care professional. It does not mean the various vehicles used, or the homes or places that health care professionals visit when seeing patients.

Detailed guidance about primary medical services and location can be read in our `quick reference guide: GP out of hours services which can be found on our website.
http://www.cqc.org.uk/content/gp-practices-and-out-hours-service-providers

Rule 5

A location is: The branch of an agency providing care

Where a service provider is an agency that supplies staff to undertake regulated activities in people's private homes (see rule 2), then each office from where the activities of those staff are directly managed will be a location. These are known as 'branches'.'Agency' can mean a Domiciliary Care Service, Extra Care Housing, Supported Living Services or lived-in services.

Any given office WILL NOT be classed as a branch if it is:

- A private home used only for 'on-call', or
- A private home AND client/worker records are not stored there, or
- A private home AND it is not the primary base of the agency, or
- A facility for the storage of records or another purely administrative function, or
- Temporary premises, such as hotels or serviced offices used for short periods as a convenient location for recruitment, or
- Premises used solely as accommodation addresses to receive mail or diversion of phone calls.

But it WILL be classed as a branch if, for example:

- Office premises are regularly used for 'on-call' services, especially for more than one branch, or
- They are local office bases within sheltered housing complexes, or to provide a local contact point for clients.

Examples might include:

– Agency A provides personal care to people in their own private homes from one office which is their HQ. This main HQ office supports the staff team who work out in the community, booking the work, processing their timesheets, supervising staff and possibly providing training from this location. This will be the sole location for the service provider.

– Agency B provides personal care to people in their own private homes from six sub-offices located across a large geographical area. Each of these offices supports the staff team who work out in the community from that office, booking the work, processing their timesheets, supervising staff and possibly providing training. They also have an HQ office from which no care services are actually managed and a records storage facility on an industrial estate. Each of the six offices from where the care services are managed will be a location,

but the HQ and the records storage facility will not.

- Agency C provides a range of services; some might include those outlined in examples (A) and (B) above, but it also provides personal care to people who live in supported living accommodation. People living in the supported living houses might need various hours of support from staff as they will have individual needs. Agency C might provide 24-hour support with a regular staff team working in people's houses. The staff are managed from the agency's HQ (although staff have a small base in each house to keep care records), and this will be the location for the service provider, not the individual houses in which care is provided.

- Agency D works in the same way as example (C) above, but has only one house in which care is provided. The staff and business are managed directly from a substantial office in the house itself, and therefore the house itself will be the location for the service provider.

- Shared Lives scheme A (previously known as Adult Placement schemes) arranges accommodation at a carer's home (which might be owned or rented by the carer) for people who may need support with specific needs i.e. learning disabilities or mental health. The carers' homes will not be locations in their own right, but will fall under the service provider's HQ as the sole location.

Rule 6

A location is: A regional headquarters from where a national or cross-regional independent ambulance service is managed

Where a service provider is an independent ambulance service (that is, not an ambulance service operated and managed by an English NHS body, see rule 8), in many cases the service will operate within one region and be managed from one location. In that case, rule 8 will apply.

However, some independent ambulance services cover all of England, and some operate in multiple distinct regions within England. In those cases, the regional headquarters – meaning the place from which operational management takes place for a region – will be a location. The characteristics of a regional headquarters will include, but are not restricted or limited to:

- Its function includes the operational management of the independent ambulance service from a defined region.
- Where the provider has a national service covering all of England, designation of regional headquarters will be required and the provider must determine the size and boundaries of each region depending on what is practicable for them to be able to demonstrate compliance.
- Where the provider has a cross-regional service covering more than one region of England, designation of regional headquarters will be required. We do not offer a definition of 'region'. The principle is that regional headquarters must be designated wherever it is not practicable for a provider to demonstrate compliance through one location, because it is not feasible for one manager to be accountable for day-to-day running of the service and the different operational requirements of its very large or distinct areas. In these cases, the provider is responsible for ensuring that the arrangement is practicable, bearing in mind that inability to do so may call into question the fitness of the entire provider to manage the service.

Note: For NHS ambulance services, please see rule 8.

Rule 7

A location is: A stand alone purpose-built diagnostic or screening facility

Where service providers carry on the regulated activity of diagnostic and screening procedures directly to people using the service in a stand alone, fixed site facility built for the purpose of undertaking such procedures, the place in which that service is provided is a location. Where a service is covered within the mobile rule in rule 8 (i.e. the facility is a vehicle of some form), then this rule will not apply. Examples of such facilities include stand alone health assessment services, stand alone CT or MRI scanning services, stand alone foetal screening services, medical laboratories that directly receive people in order to give or take samples and specimens etc.

Rule 8

A location is: A place from where regulated activities are managed

Where a service provider delivers regulated activities in places that do not meet any of the above rules, those services must be included under either:

a) Another location that is being registered by the service provider under categories 1 to 7 above, or

b) At the service provider's HQ address.

If it is the case that such services are managed from a main location, and do not satisfy any of the other location rules, the provider still needs to ensure that the requirements of regulations are being met in the provision of activity at these places

Examples to illustrate 8(a):

- A satellite outpatient clinic that serves an acute hospital, but that does not fall into any of the categories 1 to 7 above in its own right. Where this is the case, the clinic can be included as part of the service provider's registration at the location of the acute hospital, regardless of geographical location. Where that outpatient clinic serves more than one acute hospital location, the service provider can decide at which of its other locations it is most appropriate for the clinic's services to be included.

- A small medical laboratory that is a satellite of a larger medical laboratory and that only analyses samples (it does not receive people to take samples).

Examples to illustrate 8(b):

- Community services such as health visiting, district and school nursing services, community mental health teams, hospital-at-home, palliative care services and many others are provided in a variety of settings including health centres, people's 'private homes' (see 2(b)), community centres, supermarkets, etc. These places will not need to be classed as locations in their own right. All these types of places where services are provided will fall under the service provider's HQ as the location. This will be the case even though those community services may be operationally managed from a place other than the service provider's HQ. The Statement of Purpose will set out the individual addresses that comprise each group of main locations and their associated satellites.

  This applies even where community services are provided within the same premises as primary medical, primary out-of-hours, primary dental service or a walk-in centre, and where these services fulfil the criteria for being a location in their own right. Those community services will **not** be included within the GP, out-of-hours service, dentist or walk-in centre's location, but will be included within the service provider's HQ address. This will be the case even though those community services may be operationally managed from a place other than the service provider's HQ.

- All ambulance services that are operated and managed by an English NHS body, and wherever they are provided from, will fall into the service provider's HQ address as one location. We do not consider places to be locations where it is a place in the community where a vehicle is temporarily parked, landed or anchored as a holding or stand-by point, or the place where it is parked, landed or anchored while responding to a call for assistance.

- Independent ambulance services that are operated and managed in or from a single region will fall into the provider's HQ address as one location. Although this will still allow for journeys outside of the region, operational management is still overseen in day-to-day detail at the HQ and all vehicles will normally be based within the single region. If there is a distinct service in another region, with its own requirements for day-to-day management which cannot reasonably be covered from the HQ, then rule 6 will apply.

- Mobile medical facilities such as mobile surgical, endoscopy or diagnostic imaging services that are carried on in a vehicle that travels to different places to provide the regulated activity. Under former legislation, these vehicles have traditionally

been registered individually, however, the vehicles used by service providers to carry on a regulated activity will now be placed under the service provider's HQ location, in the same way as for ambulance services in the paragraph above.

- Stand alone medical laboratories (usually carrying on only the regulated activity of 'diagnostic and screening procedures') as described in rule 7, but which do NOT receive people for the purposes of giving or taking specimens.

- Where a healthcare professional or a partnership comprising healthcare professionals carries on a regulated activity from a consulting room (and which does not fall into any of the rules above), the address from which that regulated activity is provided is a location. Where a medical professional or a partnership comprising healthcare professionals carries on a regulated activity for which the service provider travels to a variety of places to provide the care or treatment to people (for example in their permanent private residence or temporary address such as a hotel) the service provider can select the address from where they manage their service as the location.

Other rules

Rule 9: Locations for regulated activities where partnership, jointly-funded, integrated care or other arrangements are in place and where services are carried on between or on behalf of service providers in a range of places

The Health and Social Care Act 2008 requires that "any person" who carries on a regulated activity must be registered to provide it. "Any person" can be an individual, a partnership or a body other than a partnership - such as a local authority, NHS trust, limited company, voluntary body or sole-trader.

There are numerous examples where a service provider may enter into a formal or informal arrangement for the provision or subcontracting of services that has an impact on deciding, firstly, who the registered person is, and secondly, the “ownership” of locations.

Examples can include, but are not limited to:

- A section 75 arrangement (National Health Service Act 2006, or, previously section 31 of the Health Act 1999) where a service is being jointly funded by an NHS trust and a local authority
- Services provided by service provider A on service provider B’s premises for the benefit of service provider B’s service users.
- Services provided by service provider A on service provider B’s premises for the benefit of service provider A’s service users, under either temporary or longer-term arrangements.

Section 75 of the Health Act 2006 empowers local authorities and NHS bodies to cooperate in providing some of the services they are each obliged by statute to provide, and some of the arrangements reached under section 75 amount to a type of partnership arrangement. However, CQC takes the view that such arrangements do not constitute a legal partnership, and so do not mean that a partnership has replaced either the NHS body or the local authority as the service provider for the purposes of the Health and Social Care Act. The "person" who should be registered to provide any particular regulated activity is the body (NHS trust or council) that has the original statutory power or obligation to provide that service.

The legislation provides only for English NHS bodies to be registerable for regulated activities by 1 April 2010. Service providers that are not an English NHS body and that provide

registerable services do not need to be registered until October 2010. Following on from this, CQC takes the view that NHS trusts should be applying to be registered as the provider of services that involve a regulated activity coming within their statutory remit before April 2010, while local authorities should be doing so before October 2010, regardless of any section 75 arrangements they may have made.

CQC also takes this principle to apply to any other informal or formal partnership or subcontracting arrangement in terms of identifying who is the "person" who should be registered. That means where service provider A retains statutory responsibility or other overall accountability for the provision of a regulated activity, irrespective of whether service provider B is involved in that provision, service provider A will need to include that part of the service within their registration for the relevant regulated activity(ies).

Where two or more service providers have shared accountability for a service, each will have to include the part of the service they have accountability for in their application at the relevant time during 2010.

Although this may appear cumbersome, it is important that the service provider who ultimately holds responsibility is the registered person for the purposes of registration, compliance and enforcement.

Service providers must register for each of the regulated activities they provide. It is unlikely that any service provider will be carrying on regulated activities under partnership and other arrangements that differ from those they will already be registered to provide as their "main" service. Therefore, their registration is likely to be affected only in terms of deciding at which location they are providing a service, and so they must determine how these location rules apply to their "other" services.

The service provider who needs to be registered will need to apply the location rules set out above to each part of their service for the regulated activities they are applying for.

For NHS service providers, examples might include:

- Primary care trust (PCT) A provides a range of community health services that are registered under the location of the PCT's headquarters. PCT A and local authority B jointly manage a crisis response service that is formalised under a Section 75 Agreement (National Health Service Act 2006). The response service is delivered by integrated multi-professional teams; it provides a single point of contact and a

range of health and social care services including community intermediate care, a number of community hospital beds and a residential care facility. Both PCT A and local authority B will need to include this integrated service in their registration. Each will have to register the aspect of the service for which they have overall accountability. For PCT A, this will be included in their PCT's headquarters registration location.

- NHS trust A, a foundation trust hospital, provides specialist nursing and medical staff to NHS trust B, an acute hospital, under a service level agreement, to carry out services that fall within a range of regulated activities and that are carried out in a number of departments across trust B's hospital sites. The patients are the responsibility of trust B. Trust B holds the responsibility under the Regulated Activities regulations for ensuring that the staff it is using from trust A are fit, and is overall accountable for the delivery of that service, even though it is being delivered by trust A's staff. In this case, trust A is not required to include this service within its own application for regulated activities, and it does not need to list the locations belonging to trust B within that application.

- NHS trust A is a specialist hospital and receives referrals for specialist treatment for patients from NHS trust B. Usually, patients from trust B travel to trust A's premises, but, as this is in a different city, trust A is piloting the provision of a specialist service within trust B's premises once a month so that patients don't have to travel long distances. In this case, trust A is the service provider with responsibility for the patients as they have been referred from trust B, so trust A must include this monthly service within its registration.

  Depending on whether the service falls into location categories 1 to 4 above, NHS trust A may either list the premises it uses at NHS trust B's hospital as a separate location in its own right, or, include it as a satellite outpatient clinic serving one of trust A's acute hospital locations. In either event, trust A will be responsible for ensuring that the part of trust B's premises it is using for carrying on the regulated activity meets relevant regulations. In addition, if the premises being used is defined as a location and the pilot is discontinued, trust A will need to apply for a variation to its conditions of registration to remove that location.

  In this example, trust B is not required to include this service within its own application for regulated activities.

- NHS trust A has negotiated a temporary lease arrangement with a local independent hospital service provider. This is for

use of the independent service provider's premises to provide surgical procedures while its own premises are being upgraded. Trust A's staff carry out the surgical procedures, but the post-operative recovery is provided by the independent hospital's staff under a service level agreement. Trust A is the service provider as it holds overall responsibility for the patients, even though they are being treated in the independent hospital's facilities and with shared care provided by different staff. Trust A will be responsible for ensuring that the parts of the independent service provider's premises that it is using to carry on the regulated activity meet relevant regulations, and that the staff providing care or treatment for its patients satisfy the fitness regulations.

In this example, as surgical procedures and post operative care are being provided, the locations criteria for listing this as a separate location on trust A's registration will apply to this temporary arrangement. In addition, if the premises being used is defined as a location and the temporary arrangement is discontinued, trust A will need to apply for a variation to its conditions of registration to remove that location

- An independent hospital service provider runs a private patient unit within NHS Trust A's premises. This unit is registered with CQC under the Care Standards Act 2000, and has a registered manager on site. There is a formal lease arrangement for the use of the ward space, operating theatres and other clinical and ancillary services. The nursing staff are employed by the independent service provider, consultants work under practicing privileges arrangements with the service provider, all other staff work under the service level agreement. In this example, the service provider is the independent hospital, and, when it is required to re-apply for registration under the 2008 Act, it will need to include this place as a location in its own right within its application. In this example, trust A is not required to include this service within its own application for regulated activities.

For other service providers it is less likely that the type of 'hosting' arrangements would include the hosting of services that, in themselves, would be regarded under rules 1 to 7 as separate locations.

Where scenarios are identified that mean two separate service providers are involved with a service that, for both of them, would trigger that place as a location under rules 1 to 7, then the NHS scenarios can be used (set out above in examples a) to e) above) to determine how they should be managed for the purposes of this guidance.

Rule 10: Emergency remote clinical advice and triage

Services such as NHS Direct do not easily sit within the criteria described in rules 1 to 7 above. All of the services are provided remotely, in that there is no face-to-face contact with people who use the service and no places in which people are treated. For this reason, all medical advice services* should be grouped into one location at the service provider's HQ address.

* This rule only applies to "medical advice" in cases where immediate action or attention is needed, or triage provided, over the telephone or by email by a body established for that purpose.

Rule 11: NHS trusts providing care home or domiciliary care services

There are a number of primary care, mental health and learning disability trusts that are providing care home or domiciliary care-type social care services. Examples of the services provided include assessment or respite care provided to people with mental health problems or learning disabilities, care provided by the trust to people in their own homes, and care for people with substance misuse problems.

In the earlier version of this guidance, prepared for NHS registration in January 2010, we advised that NHS service providers of care home or domiciliary care services that are not registered under the CSA would need to register these from 1 April under the location of the trust's headquarters.

These rules have now been amended and NHS providers of social care services will now need to identify the locations of all the individual care home or domiciliary care services in line with the rules set out in this guidance.

University Hospitals of Leicester NHS Trust
Statement of Purpose
May 2019

Statement of Purpose, Part 1

Provider's name and legal status	
Full name	**University Hospitals of Leicester NHS Trust**
CQC provider ID	**RWE**
Legal status	**Organisation**

Provider's address, including for service of notices and other documents	
Business address	**Trust HQ, Level 3 Balmoral Building Leicester Royal Infirmary Infirmary Square**
Town/city	**Leicester**
County	**Leicestershire**
Postcode	**LE1 5WW**
Business telephone	**0116 258 5938**
Email	**Helen.harrison@uhl-tr.nhs.uk**
Chief Executive	**John Adler**
Chief Executive Email	**john.adler@uhl-tr.nhs.uk**

Statement of Purpose, Part 2

Aims and objectives
What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

University Hospitals of Leicester NHS Trust (UHL) is one of the ten largest Trusts in the country and a leading teaching hospital with one of the strongest research portfolios outside of the "Golden Triangle". We provide hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland (LLR) and specialist services to patients throughout the UK. As such, the main sources of income are derived from Clinical Commissioning Groups (CCGs), NHS England, and education and training levies.

Our five-year plan, "Delivering Caring at its Best" is ambitious, as is that of the wider health economy, which is now described in the local Sustainability and Transformation Plan (STP). Our STP builds on the work of our Better Care Together programme, the plans of which were already well advanced and articulated in many areas, particularly around proposals for reconfiguring acute hospital services to address long standing issues around the condition of our premises and how these are utilised.

Together, our plans will see UHL become a Trust that is renowned for placing quality, safety and innovation at the centre of service provision. We will continue to build on our strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience. We call this 'Caring at its Best'.

Our vision is underpinned by a set of corresponding values. These values were developed with staff and reflect the things that matter most to them and the Trust.

Strategic objectives

We have reshaped our 5 year strategic objectives this year to provide even more focus on what matters most in terms of delivering our strategy.

In the centre is our Quality Commitment, putting safe, high quality patient-centred, efficient care at the centre of everything we do. This is our primary objective. Everything else will support the delivery of that:

Our People: We will have the right people with the right skills in the right numbers in order to deliver the most effective care

Education and Research: We will deliver high quality, relevant, education and research

Partnerships and Integration: We will develop more integrated care in partnership with others

Key Strategic Enablers: We will progress our key strategic enablers such as progressing towards a paperless hospital and enacting our plans for reconfiguration

The Alliance

2018/19, marked the fifth year of the LLR Alliance - a partnership between University Hospitals of Leicester, Leicestershire Partnership NHS Trust, the LLR Provider Company who are the providers and the three Clinical Commissioning Groups that cover Leicester, Leicestershire and Rutland (LLR).

The LLR Alliance supports the delivery of a range of elective care outpatients, day-case procedures and diagnostics from community hospital sites and primary care sites across the county.

All partners in the LLR Alliance are part of an overarching agreement, with shared risk and reward. The provider participants each have a 'pillar contract' based on the National NHS Standard Contract, with the same performance standards and an indicative activity plan which sets out the services that each provider is responsible for delivering. This document refers to those locations where Alliance UHL Pillar activity operates from.

Statement of Purpose, Part 3

Name of location	**Leicester Royal Infirmary**
Address	**Infirmary Square, Leicester**
Postcode	**LE1 5WW**
Business telephone	**0300 303 1573**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The Leicester Royal Infirmary has 982 beds and provides Leicestershire's only accident and emergency service (our Emergency Department). It is also the base for our Children's Hospital Satellite units: • Rutland Memorial Hospital (satellite unit Rule 8a) • Feilding Palmer Hospital (satellite unit Rule 8a) • Coalville Hospital (satellite unit Rule 8a)

CQC service user bands					
Adults aged 18-65		Adults aged 65+			
Mental health		Sensory impairment			
Physical disability		People detained under the Mental Health Act			
Dementia		People who misuse drugs or alcohol			
People with an eating disorder		Learning difficulties or autistic disorder			
Children aged 0 – 3 years		Children aged 4-12		Children aged 13-18	
The whole population	✓	Other (please specify below)			

The CQC service type(s) provided at this location
Acute service (ACS)
Hospice services (HPS)
Rehabilitation services (RHS)
Long-term conditions services (LTC)
Community healthcare services (CHC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Assessment or medical treatment for persons detained under Mental Health Act 1983

Surgical procedures
Diagnostic and screening procedures
Maternity and midwifery services
Termination of pregnancies
Family Planning

Name of location	**Rutland Memorial Hospital (satellite unit Rule 8a)**
Address	**Cold Overton Road** **Oakham** **Leicestershire**
Postcode	**LE15 6NT**
Business telephone	**01509 564493**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
Rutland Memorial Hospital is located in the town of Oakham in Leicestershire. The landlord for this property is the Leicestershire Partnership NHS Trust. The UHL pillar of the Alliance activity operates from this multiple occupancy site. A variety of Radiological diagnostic activity (plain film and ultrasound) is carried out, there is 1 outpatient department.

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			✓
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years	✓	Children aged 4-12	✓	Children aged 13-18	✓
The whole population		Other (please specify below)			

The CQC service type(s) provided at this location
Long-term conditions services (LTC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Feilding Palmer Hospital (satellite unit Rule 8a)**
Address	**Gilmorton Road Lutterworth Leicestershire**
Postcode	**LE17 4DZ**
Business telephone	**01509 564493**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
Feilding Palmer Hospital is located in Lutterworth, Leicestershire. Outpatient services only operate form this site. The landlord for this property is the Leicestershire Partnership NHS Trust. The UHL pillar of the Alliance activity operates from this multiple occupancy site.

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years	✓	Children aged 4-12	✓	Children aged 13-18	✓
The whole population		Other (please specify below)			✓

The CQC service type(s) provided at this location
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Coalville Hospital (satellite unit Rule 8a)**
Address	**Broom Leys Road, Coalville, Leicestershire**
Postcode	**LE67 4DE**
Business telephone	**01509 564493**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
Coalville Hospital is located in Coalville town, Leicestershire. Coalville Hospital has an outpatient suite and provides a variety of radiological diagnostic services. The landlord of this property is Leicester Partnership NHS Trust. The UHL pillar of the Alliance activity operates from this multiple occupancy site.

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years	✓	Children aged 4-12	✓	Children aged 13-18	✓
The whole population		Other (please specify below)			

The CQC service type(s) provided at this location
Long-term conditions services (LTC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Glenfield Hospital**
Address	**Groby Road, Leicester**
Postcode	**LE3 9QP**
Business telephone	**0300 303 1573**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
Glenfield Hospital has approximately 440 beds and provides a range of services for patients, including nationally recognised medical care for heart disease, lung cancer and breast care.

CQC service user bands					
Adults aged 18-65		Adults aged 65+			
Mental health		Sensory impairment			
Physical disability		People detained under the Mental Health Act			
Dementia		People who misuse drugs or alcohol			
People with an eating disorder		Learning difficulties or autistic disorder			
Children aged 0 – 3 years		Children aged 4-12		Children aged 13-18	
The whole population	✓	Other (please specify below)			

The CQC service type(s) provided at this location
Acute service (ACS)
Hospice services (HPS)
Rehabilitation services (RHS)
Long-term conditions services (LTC)
Community healthcare services (CHC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Assessment or medical treatment for persons detained under Mental Health Act 1983
Surgical procedures
Diagnostic and screening procedures
Termination of pregnancies

Name of location	**Leicester General Hospital**
Address	**Gwendolen Road, Leicester**
Postcode	**LE5 4PW**
Business telephone	**0300 303 1573**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The Leicester General Hospital has 390 beds and provides a range of medical services including care at our national centre for renal and urology patients.

CQC service user bands				
Adults aged 18-65	✓	Adults aged 65+		✓
Mental health	✓	Sensory impairment		✓
Physical disability	✓	People detained under the Mental Health Act		✓
Dementia	✓	People who misuse drugs or alcohol		✓
People with an eating disorder	✓	Learning difficulties or autistic disorder		✓
Children aged 0 – 3 years	✓	Children aged 4-12	Children aged 13-18	✓
The whole population		Other (please specify below)		

The CQC service type(s) provided at this location
Acute service (ACS)
Hospice services (HPS)
Rehabilitation services (RHS)
Long-term conditions services (LTC)
Community healthcare services (CHC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Assessment or medical treatment for persons detained under Mental Health Act 1983
Surgical procedures
Diagnostic and screening procedures
Maternity and midwifery services
Termination of pregnancies
Family planning

Name of location	**Northampton Renal Dialysis Unit (satellite unit)**
Address	**Riverside House, Riverside Way Industrial Estate, Bedford Road, Northampton**
Postcode	**NN1 5NX**
Business telephone	**01604 628976**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The unit has the capacity for 26 stations and 3 isolation rooms and treats patients from the Northampton area.

CQC service user bands	
Adults aged 18-65	Adults aged 65+
Mental Health	Sensory impairment
Physical disability	People detained under the Mental Health Act
Dementia	People who misuse drugs or alcohol
People with an eating disorder	Learning difficulties or autistic disorder

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health	✓	Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			✓
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years		Children aged 4-12		Children aged 13-18	
The whole population		Other (please specify below)			

The CQC service type(s) provided at this location
Acute services (ACS)
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Kettering Dialysis Unit (satellite unit)**
Address	**5 Trafalgar Road, Kettering, Northants**
Postcode	**NN16 8DB**
Business telephone	**01536 512535**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The unit has 20-26 Haemodialysis Stations and 3 Isolation rooms and treats patients from around the Kettering area.

CQC service user bands				
Adults aged 18-65	✓	Adults aged 65+		✓
Mental health	✓	Sensory impairment		✓
Physical disability	✓	People detained under the Mental Health Act		✓
Dementia	✓	People who misuse drugs or alcohol		✓
People with an eating disorder	✓	Learning difficulties or autistic disorder		✓
Children aged 0 – 3 years		Children aged 4-12	Children aged 13-18	
The whole population		Other (please specify below)		

The CQC service type(s) provided at this location
Acute services (ACS)
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Lincoln Renal Unit (satellite unit)**
Address	**Lincoln County Hospital, Greetwell Road, Lincoln, Lincolnshire**
Postcode	**LN2 5QY**
Business telephone	**01522 573561**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The unit is on the Lincoln County Hospital site, although separate from the main building. Inpatients requiring dialysis are transferred via ambulance to the unit. The unit has 12 stations and 2 isolation rooms and 3 inpatient stations.

CQC service user bands				
Adults aged 18-65	✓	Adults aged 65+		✓
Mental health	✓	Sensory impairment		✓
Physical disability	✓	People detained under the Mental Health Act		✓
Dementia	✓	People who misuse drugs or alcohol		✓
People with an eating disorder	✓	Learning difficulties or autistic disorder		✓
Children aged 0 – 3 years		Children aged 4-12	Children aged 13-18	
The whole population		Other (please specify below)		

The CQC service type(s) provided at this location
Acute services (ACS)
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Peterborough Renal Unit (satellite unit)**
Address	**Peterborough City Hospital, Edith Cavell Campus, Bretton Gate, Peterborough**
Postcode	**PE3 9GZ**
Business telephone	**01733 67888**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The unit is situated in the new Peterborough City Hospital and has 15 stations and 2 isolation room.

CQC service user bands				
Adults aged 18-65	✓	Adults aged 65+		✓
Mental health	✓	Sensory impairment		✓
Physical disability	✓	People detained under the Mental Health Act		✓
Dementia	✓	People who misuse drugs or alcohol		✓
People with an eating disorder	✓	Learning difficulties or autistic disorder		✓
Children aged 0 – 3 years		Children aged 4-12	Children aged 13-18	
The whole population		Other (please specify below)		

The CQC service type(s) provided at this location
Acute services (ACS)
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Dr Chandra Mistry Haemodialysis Unit (satellite unit)**
Address	**The Westwood Park Farm, Peterborough**
Postcode	**PE3 9UW**
Business telephone	**TBC**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The unit has 8 Haemodialysis Stations and 2 Isolation Rooms

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health	✓	Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			✓
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years		Children aged 4-12		Children aged 13-18	
The whole population		Other (please specify below)			

The CQC service type(s) provided at this location
Acute services (ACS)
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Hinckley Health Centre & Hinckley and District Hospital**
Address	**Mount Road , Hinckley, Leicestershire**
Postcode	**LE10 1AG**
Business telephone	**01509 564493**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
Hinckley Health Centre & Hinckley and District Hospital are located in Hinckley town in Leicestershire. Hinckley Health Centre has an outpatient suite and Hinckley District Hospital has an endoscopy suite and a day case unit and offers a variety of radiological diagnostic services. The UHL pillar of the Alliance activity operates from this multiple occupancy site. The landlord for this site and both properties is NHS Property Services.

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years	✓	Children aged 4-12	✓	Children aged 13-18	✓
The whole population		Other (please specify below)			✓

The CQC service type(s) provided at this location
Long-term conditions services (LTC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures

Name of location	**Loughborough Hospital**
Address	**Hospital Way, Loughborough, Leicestershire**
Postcode	**LE11 5JY**
Business telephone	**01509 564493**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
Loughborough Hospital is located within the town of Loughborough in Leicestershire. The UHL pillar of the Alliance activity operates from this multiple occupancy site. The landlord for this property is Leicestershire Partnership NHS Trust. The UHL pillar of the Alliance activity operates from this multiple occupancy site. Loughborough Hospital has two outpatient departments', an endoscopy unit, a variety of diagnostic radiological services and a surgical day case unit. A 14 station dialysis unit is also located at Loughborough Hospital. This activity is provided under UHL, not the UHL pillar of the Alliance.   

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years	✓	Children aged 4-12	✓	Children aged 13-18	✓
The whole population		Other (please specify below)			✓

The CQC service type(s) provided at this location
Long-term conditions services (LTC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury

Surgical procedures
Diagnostic and screening procedures

Name of location	**St Luke's Treatment Centre & Endoscopy Suite**
Address	**33 Leicester Road, Market Harborough, Leicestershire**
Postcode	**LE16 7BN**
Business telephone	**01509 564493**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
St Luke's Treatment Centre and Endoscopy Suite is located on the edge of Market Harborough in Leicestershire. The UHL pillar of the Alliance activity operates from this multiple occupancy site. The landlord for this property is NHS Property Services. Whilst co-located on the same site, the Treatment Centre and Endoscopy Suite are based in different buildings. The treatment centre carries out plain film radiological diagnostic services and has one outpatient department. The Endoscopy Unit carries out endoscopies.

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			✓
Physical disability	✓	People detained under the Mental Health Act			
Dementia	✓	People who misuse drugs or alcohol			✓
People with an eating disorder	✓	Learning difficulties or autistic disorder			✓
Children aged 0 – 3 years	✓	Children aged 4-12	✓	Children aged 13-18	✓
The whole population	✓	Other (please specify below)			✓

The CQC service type(s) provided at this location
Long-term conditions services (LTC)
Diagnostic and screening services (DSS)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Name of location	**Melton Mowbray Hospital and St Mary's Birthing Centre**
Address	**Thorpe Road, Melton Mowbray, Leicestershire**
Postcode	**LE13 1SJ**
Business telephone	**01664 854 854**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location

Melton Mowbray Hospital and St Mary's Birthing Centre are located in the town of Melton Mowbray in Leicestershire. The landlord for both of these properties is NHS Property Services.

Whilst co-located on the same site, Melton Mowbray Hospital and St Mary's Birthing Centre are based in different buildings.

The UHL pillar of the Alliance activity operates from Melton Mowbray Hospital which is a multiple occupancy site. Melton Mowbray Hospital has an outpatient suite, an endoscopy suite and one surgical day case unit. A radiology diagnostic service is run from this site

St Mary's Birth Centre provides care for low risk pregnant women and their families before, during and after birth. This activity is provided under UHL, not the UHL pillar of the Alliance.

Melton Mowbray Hospital

St Mary's Birthing Centre

CQC service user bands					
Adults aged 18-65		Adults aged 65+			
Mental health		Sensory impairment			
Physical disability		People detained under the Mental Health Act			
Dementia		People who misuse drugs or alcohol			
People with an eating disorder		Learning difficulties or autistic disorder			
Children aged 0 – 3 years		Children aged 4-12		Children aged 13-18	
The whole population	✓	Other (please specify below)			

The CQC service type(s) provided at this location
Acute service (ACS)
Community healthcare services (CHC)
Diagnostic and screening services (DSS)
Long-term conditions services (LTC)

Regulated activity(ies) carried out at this location
Treatment of disease, disorder or injury
Surgical procedures
Diagnostic and screening procedures
Maternity and midwifery services
Family Planning

Name of location	**National Centre for Sports & Exercise Medicine – East midlands (NCSEM-EM)**
Address	**Loughborough University, Ashby Road, Loughborough, Leicestershire**
Postcode	**LE11 3TU**
Business telephone	**01509 222444**
Email	**john.adler@uhl-tr.nhs.uk**

Description of the location
The National Centre for Sports and Exercise Medicine, East Midlands (NCSEM-EM) is part of the 2012 Olympic Health legacy, funded by the Department of Health and its aim is to improve the nation's health through sports exercise and physical activity. The NCSEM-EM is situated on Loughborough University Campus and clinical provision includes 9 outpatient consulting rooms and a diagnostic suite.

CQC service user bands					
Adults aged 18-65	✓	Adults aged 65+			✓
Mental health		Sensory impairment			
Physical disability		People detained under the Mental Health Act			
Dementia		People who misuse drugs or alcohol			
People with an eating disorder		Learning difficulties or autistic disorder			
Children aged 0 – 3 years		Children aged 4-12		Children aged 13-18	
The whole population		Other (please specify below)			

The CQC service type(s) provided at this location
Long-term conditions services (LTC)
Diagnostic and screening services (DSS)

Regulated activities carried out at this location
Treatment of disease, disorder or injury
Diagnostic and screening procedures

Summary of Regulated Activities by Location							
	Treatment of disease, disorder or injury	Assessment or medical treatment for persons detained under MHA1983	Surgical procedures	Diagnostic and screening procedures	Maternity and midwifery services	Termination of pregnancies	Family planning services
Glenfield Hospital (RULE 1)	X	X	X	X		X	
Leicester Royal Infirmary (RULE 1)	X	X	X	X	X	X	X
Satellite units (The Alliance):							
• **Rutland Memorial Hospital (RULE 8a)**	X			X			
• **Feilding Palmer Hospital (RULE 8a)**	X			X			
• **Coalville Hospital (RULE 8a)**	X			X			
Lincoln Renal Unit (RULE 1)	X			X			
Dr Chandra Mistry Haemodialysis Unit (RULE 1)	X			X			
Northampton Renal Dialysis Unit (RULE 1)	X			X			
Kettering Dialysis Unit (RULE 1)	X			X			
Peterborough Renal Unit (RULE 1)	X			X			
Hinckley Health Centre & Hinckley and District Hospital (RULE 1)	X		X	X			
Loughborough Hospital (RULE 1)	X		X	X			
St Luke's Treatment Centre and Endoscopy Suite (RULE 1)	X			X			
St Marys Birth Centre & Melton Mowbray Hospital (RULE 1)	X		X	X	X		X
National Centre for Sports and Exercise Medicine	X			X			