University Hospitals of Leicester NHS
NHS Trust

Public Trust Board paper F3

Meeting title:	Trust Board
Date of the meeting:	9 October 2025
Title:	**Escalation Report from the Quality Committee (QC): 28 August 2025**
Report presented by:	Dr Andy Haynes, Quality Committee Non-Executive Director Chair
Report written by:	Hina Majeed, Corporate and Committee Services Officer

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Yes. BAF risk within the remit of QC is listed below:
Quality Risks (BAF reference: 01-Quality)

1) There is a risk that a positive safety culture is not consistently embedded across services, due to underreporting and variable staff confidence in raising concerns and learning from incidents, leading to patient harm, low morale, reputational damage, and non-compliance with safety standards
2) There is a risk that hospital-acquired infections and harm do not reduce as planned, due to inconsistent delivery of fundamentals of care, overcrowding and variable protocol compliance, leading to avoidable harm, longer stays, cost pressures, and reduced confidence in care
3) There is a risk that patients, families, and carers are not fully engaged in service development and feedback, due to limited access to and responsiveness of engagement mechanisms, leading to unmet needs, dissatisfaction, and increased complaints
4) There is a risk that care for patients with mental health needs, learning disabilities, autism, dementia, or at end of life remains inconsistent, due to variable screening, staff training, and service capability, leading to poorer outcomes, readmissions, and non-compliance with national standards
5) There is a risk that patients from underserved groups continue to experience poorer access, communication, and outcomes, due to insufficient data insights, inconsistent reasonable adjustments, and language/cultural barriers, leading to continued health inequalities and dissatisfaction among diverse patient groups, missed appointments, and reputational damage

Impact assessment

N/A

Acronyms used:
CMG – Clinical Management Group
CQC – Care Quality Commission
NICE- National Institute for Health Care and Excellence
PALS – Patient Advice and Liaison Service
VTE - Venous Thromboembolism

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee and escalate any issues as required.

2. Summary

The Quality Committee met on 28 August 2025 and was quorate. It considered the following items, and the discussion is summarised below:

3. Public items recommended to the Trust Board: -

3.1 Mortality and Learning from Deaths (LfD) Quarterly Report

UHL's crude mortality rates (SHMI and HSMR) were stable and within expected ranges. UHL recorded a higher percentage of patients with zero comorbidities, a new coding practice was implemented in May 2025, with expected impact visible in 4-6 months. The LLR Medical Examiner Service 'turn around times' had improved following the initial 'post implementation phase' and increased winter activity. The team aimed to issue death certificates within 2 days, targeting a 90% success rate. Service reconfiguration was underway to meet this goal. In respect of the learning from deaths programme, four deaths during quarter 1 of 2025-26 had been considered more likely than not due to issues in care, common themes were diagnosis, management and communication.

The Committee reviewed current trends and assurance processes related to perinatal mortality, with a focus on neonatal deaths and stillbirths. While neonatal mortality rates were declining, a slight increase in stillbirths was noted. The team was actively engaging in external benchmarking and peer reviews to validate internal findings and improve review quality. Structured Judgement Reviews (SJRs) and coding practices were being enhanced to ensure accurate data and timely identification of safety concerns. The Committee expressed confidence in the robustness of internal processes and welcomed external validation to strengthen assurance.

The Mortality and Learning from Deaths report be endorsed and recommended for Trust Board approval. A stand-alone report on this item is included on the October 2025 Trust Board agenda accordingly.

4. Discussion Items

4.1 Board Assurance Framework (BAF)

The Committee received the BAF noting the risk scores remain unchanged. There was a detailed discussion particularly in relation to understanding how the inclusion of Key Risk Indicators could provide early warning signals to show whether a strategic risk on the BAF may be getting better or worse. In discussion, it was noted that the Quality & Safety dashboard and the Quality Strategy contained relevant metrics to help the Committee anticipate any issues, focus attention on where risks may deteriorate, and assure that mitigation is working, but there was a need to explicitly map these to the BAF risks in order to strengthen assurance. The Head of Risk Assurance highlighted the need to link existing dashboard indicators to BAF risks and undertook to map these for further review with the Chief Nurse and Medical Director, aiming to clarify how indicators reflected risk movement. The Committee Chair proposed using the Executive summary of the quarterly Quality Strategy update to focus on BAF risks. The need to review possible different formats of the BAF cover report (to a pictorial/graphical presentation) and ensuring agenda items visibly addressed BAF gaps was also suggested. In conclusion, it was agreed the approach would be refined with the aim to finalise a clearer format and process by the October 2025 Quality Committee.

4.2 Quality Strategy – Quarter 1 Update

The Committee received a comprehensive update on progress during quarter 1, against UHL's Quality Strategy 2025–28. The report aimed to assure on key quality improvement initiatives, focusing on safety, amplifying patient voice, delivering outstanding care quality, and ensuring equitable care experiences, while also informing future priorities and decision-making. Members were assured with the work undertaken and noted the need to align some of the impact measures on a quarterly basis (as per discussions of the BAF report above) which would give a better understanding of progress.

4.3 NIPAG Annual Report 2024/25

The report highlighted a post-COVID decline in new procedure applications at UHL, though adoption of NICE-recommended interventions remained stable. Assurance processes were in place to monitor safety and effectiveness, with strong engagement from Clinical Directors. Cost-effectiveness was not yet formally assessed but was expected to become a future consideration.

The NIPAG Annual Report 2024-25 is appended to this report and highlighted to the Trust Board for information.

4.4 Infection Prevention governance and assurance 2025/26 – quarter 1

The Committee reviewed key infection prevention priorities and risks, with a focus on communication, tuberculosis response, estates-related infection risks, and mask fit testing compliance.

4.5 Surgical Site Infection Surveillance Report

The Trust had conducted a comprehensive review of over 2,600 surgical cases, identifying elevated Surgical Site Infection (SSI) rates in several specialties – most notably cardiac, spinal, breast, and bowel surgeries. The report highlighted significant cost burdens, gaps in theatre infection control practices, and variable compliance with NICE guidelines. Immediate training and engagement with theatre teams had been initiated, and a system-wide infection reduction strategy was being developed. The Committee agreed to quarterly reporting via the Infection Prevention assurance reports, deeper dives via the Patient Safety Committee, and trials of new wound care technologies and digital surveillance tools to improve outcomes and reduce infection rates.

This update is highlighted to the Trust Board for information.

4.6 Infection Prevention Annual Report 2024/25

The report was noted, and it was highlighted that it was a successful year from an infection prevention perspective.

The Infection Prevention Annual Report 2024-25 is appended to this report and highlighted to the Trust Board for information.

4.7 Audit and Quality Improvement Update (AQIP)

The Committee received a comprehensive report on AQIP, highlighting progress, challenges, and strategic developments in embedding a culture of continuous improvement across UHL.

4.8 National Audit of Inpatient Falls (NAIF) & UHL Falls Analysis

The NAIF Falls Update highlighted a rise in eligible cases following the expansion of NAIF criteria. While UHL had shown improvement in blood pressure monitoring and medication reviews, persistent gaps remained in vision assessments, delirium assessments, and safe manual handling. Compliance with the new Multifactorial Assessment to Optimise Safe Activity (MASA) standard was low, prompting targeted quality improvement actions and a planned relaunch of the Falls Prevention Steering Group to drive progress and embed best practices across the Trust. The 2025 NAIF national report (based on 2024 data) was expected in September 2025.

4.9 Quality and Safety Performance Report

The Chief Nurse advised that work was ongoing to improve blood transfusion traceability. The Committee also discussed the increase in instances of violence and aggression against staff, with reassurance provided that security staff were equipped with body-worn cameras and legal action was pursued where appropriate. The Trust continued to monitor and report on these issues to support staff and maintain safety.

4.10 Quality and Safety Quarterly Report including PSIRF

Members noted that the Trust was making steady progress in the implementation of PSIRF, with strong performance in incident reporting and ongoing improvements across key work streams.

4.11 Patient Experience Report

The Committee received the 2025-26 quarter 1 patient experience update including PALS/complaints turnaround times, FFT feedback and Chaplaincy Service update. Patient moves at night was raised as a concern affecting patient experience. In response, the Chief Nurse advised that while operational constraints (particularly in relation to ambulance flow) made it challenging to eliminate night moves entirely, a task and finish group had been convened, and work was underway to bring discharges earlier in the day. Some "red lines" had been established for winter, with Executive and Senior team support, and continued focus was being given to reducing excessive moves, ensuring no patients experienced multiple transfers.

4.12 Dementia Services Annual Report

Members noted the Dementia Services and Enhanced Care Annual Report 2024-25, and it was highlighted that the team had made significant progress in improving the quality of life for the Trust's patients living with dementia, providing critical support to families, and contributing towards UHL's quality and medical dementia strategy. It was also noted that, although the Dementia and Delirium Strategy Action Group had overseen key actions, areas for improvement remained, as highlighted by the National Dementia Audit. Environmental factors were raised as a priority, with ongoing collaboration with Estates and Facilities colleagues to create dementia-friendly wards. A further update in six months' time was requested focussing on the summary of achievements and actions.

The Dementia Services and Enhanced Care Annual Report 2024-25 is appended to this report and highlighted to the Trust Board for information.

5. Reports from Quality Sub-committees

The Committee noted escalation reports from:

- Patient Safety Committee 15.7.25
- Perinatal Assurance Committee

6. Items for Noting

- Integrated Performance Report – Month 4 (2025-26)
- Perinatal Surveillance Scorecard
- Data Quality and Clinical Coding Report August 2025

Meeting title:	Quality Committee					
Date of meeting:	28 August 2025					
Title	**New Interventional Procedure Authorisation Group (NIPAG)- Annual Report 2024/25**					
Presented by:	Marwan Habiba					
Report written by:	Nicola Deakins Dept. Head of Quality Assurance					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where has this report been discussed previously?	NIPAG Meeting 14/07/2025					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Assurance

Impact assessment

Acronyms used:	
NIPAG	New Interventional Procedure Authorisation Group
NIP	New Interventional Procedure
PIL	Patient Information Leaflet
IPG	Interventional Procedure Guidance
NICE	National Institute for Health and Care Excellence

Purpose of the report

This report provides assurance on the Trust's compliance with NICE Interventional Procedure Guidance (IPG) management and approval of New Interventional Procedures (NIPs) and provides an update for procedures that have been approved/or started within the Trust through 2024-25.

Recommendation

Receive this report as assurance of trust compliance with Nice Interventional Guidance via the NIPAG committee.

Receive the update on new interventions introduced within the Trust and compliance with NICE IPGS.

Summary

This report provides the committee with assurance regarding the process for implementing new interventional procedures in the Trust.

Main report details

The Board can be assured that a comprehensive process has been carried out when introducing new interventional procedures to the Trust.

New Interventional Procedures Authorising Group (NIPAG) 2024/2025 Annual Report

Chair: Marwan Habiba – Consultant Gynaecologist

Meetings held in 24/25: May 13th, 2024 (cancelled-no new procedures submitted),
July 8th, 2024,
September 9th, 2024,
November 11th, 2024,
January 13th, 2025 (cancelled-no new procedures submitted),
March 10th, 2025 (cancelled-no new procedures submitted),
May 12th, 2025

1.0 Background

1.1 The New Interventional Procedures Advisory Group (NIPAG) was established in 2004 in response to the publication of the Health Services Circular HSC 2003/011 (November 2003), which stated "medical practitioners planning to undertake new interventional procedures should seek approval from their NHS Trust's Clinical Governance Committee before doing so."

1.2 Within UHL, a new procedure is when:

- The procedure is new to UHL – this means it has not been performed in this trust before.
- The practitioner is trained – the individual performing the new procedure has already learnt and practised the technique in another healthcare setting, but it is their first time doing it within UHL.
- A doctor, no longer in a training post, is performing the procedure for the first time in their NHS clinical practice (new operator).

1.3 NIPAG's primary role is to authorise the introduction of new procedures after satisfying itself of governance needs and to oversee the governance arrangements for the introduction of new procedures into UHL.

1.4 The NIPAG Policy (B17 2005) has been updated and has been submitted to the Policy and Guideline Committee for approval.

2.0 Key discussion items (including performance against work plans/KPIs):

2.1 Consideration of New Interventional Procedure notifications submitted for 2024/2025.

2.2 NIPAG has continued to experience low activity in new notifications compared to pre-pandemic. All of the procedures that notification were submitted to the NIPAG committee in 2024/25 were approved.

2.3 Table 1 below provides an update on new procedures approved in 2024/25 and relates to those new interventional procedures that:

- Had already been submitted for NIPAG approval before the start of the 2024/25 financial year
- Were formally approved during the 2024/25 reporting period.
- An update for each submission's approval status, conditions, or follow-up requirements

Table 1

Notification	CMG	Clinical Lead
N175 - Trabecular Stent Bypass Microsurgery For Open Angle Glaucoma with Hydrus Microstent (a new method to treat glaucoma through a minimally invasive approach)	**MSS**	**Osman Lina**
An update received in January '25 explained that procedures had not yet commenced. There have been no further updates received. This will be followed up at the September NIPAG meeting to consider if the procedure should be suspended.		
N176 - Superior Sinus Venosus defect (sSVD) closure with covered stent implantation (cardiac minimally invasive intervention for anomalies in the heart)	**W&C**	**Kantzis Marinos**
Four procedures had been carried out during the last audit received. The auditing of procedures is ongoing.		
N177 - Pilonidal Sinus Laser-Assisted Closure in Children (PiLAC) (minimally invasive treatment for pilonidal sinus)	**W&C**	**Henderson Lucy**
Six procedures were performed during the last audit; however, reduced activity is expected until October '25 as the clinical lead is not at work.		
N178 - Vaginal natural orifice transluminal endoscopic surgery) hysterectomy +/- removal of ovaries and fallopian tubes (minimally invasive technique to enable hysterectomy and removal of ovaries and tubes through the vagina)	**W&C**	**Teo Rod C**
This procedure was approved in February 2024, and update received in January explained that procedures had not yet commenced. There have been no further updates received. This will be followed up at the September NIPAG meeting. NIPAG is aware that the procedure has recently been commenced. Audit awaited		
N179 - Endoscopic Discectomy/Decompression (minimally invasive technique for disc problems resulting in back pain)	**MSS**	**Basu Partha**
Procedures commenced, and audits are to be provided after the first follow-ups are completed in September '25.		
N180 - Medtronic Aurora Extravascular Implantable Cardioverter Defibrillator (EV-ICD) (an alternative to currently offered Subcutaneous Implantable Cardioverter Defibrillator or S-ICD). (new cardiac defibrillator technology)	**RRCV**	**Dhutia Harshil**

One procedure was performed on the last audit. Audits are still being requested.

2.4 Table 2 below shows the three new notifications received and discussed at NIPAG meetings in 2024/2025. These procedures are new to the Trust (either entirely new procedures or first-time use by a particular operator), and they underwent formal review at NIPAG meetings for approval.

Table 2.

Ref Title	Clinical Lead	CMG
N181- TEER Tricuspid Clip- (clip used to repair leaky tricuspid valves)	Kovac Jan	RRCV
Approved at the May 2024 meeting.		
N182- Robotic Bronchoscopy- (minimally invasive procedure that uses robotic assistance to navigate a bronchoscope)	Caruana Edward	RRCV
Approved at the January 2025 meeting.		
N184- RayPilot- (system used in the treatment of prostate cancer)	Kent Christopher	CHUGGS
Discussed at May 25 meeting – authorisation pending production of Patient Information Leaflet		

2.5 Once a new procedure is approved, the procedure is audited. Clinicians must collect data on:

- Number of cases performed
- Patient outcomes (success rates, complications, recovery times)
- Adverse events or incidents
- Patient feedback (including on Patient Information Leaflets)

2.6 NIPAG reviews audit data at regular intervals, and issues, such as unexpectedly high complication rates, are flagged for further action, which may include additional training or suspension of the procedure.

2.7 Table 3 below shows the 19 notifications in the audit stage.

Table3.

Ref Title	Clinical Lead	CMG
N182- Robotic Bronchoscopy	Caruana Edward	RRCV
N181- TEER Tricuspid Clip (percutaneous tricuspid valve repair)	Kovac Jan	RRCV
N180- Medtronic Aurora Extravascular Implantable Cardioverter Defibrillator (EV-ICD) Subcutaneous Implantable Cardioverter Defibrillator or S-ICD.	Dhutia Harshil	RRCV
N179- Endoscopic Discectomy/Decompression	Basu Partha	MSS
N178- Vaginal natural orifice transluminal endoscopic surgery) hysterectomy +/- removal of ovaries and fallopian tubes	Teo Rod C	W&C
N177- Pilonidal Sinus Laser-Assisted Closure (PiLAC)	Henderson Lucy	W&C
N176- Superior Sinus Venosus defect (sSVD) closure with covered stent implantation	Kantzis Marinos	W&C
N173 - Radiofrequency Ablation (RFA) of thyroid nodules	Harieaswar Sreemathi	CSI
N171- Sentinel Lymph Node biopsy in endometrial cancer (Laparoscopic & Robotic)	Ismail Aemn	W&C
N170- Coronary Sinus Ruducer Technology to reduce flow in the coronary sinus in cases of resistant angina.	Modi Bhavik	RRCV
N167- iSTAR Medical MINiject SuprCilli implant- (minimally invasive glaucoma surgery device designed to reduce intraocular pressure).	Osman Lina	MSS
N166- Impella CP left ventricular unloading to assist high-risk PCI as part of the CHIP BCIS-3 trial- Mechanical device insertion to assist in cases of heart failure	Ladwiniec Andrew	RRCV
N159- Trans-Oral Robotic Surgery	Olaleye Oladejo	MSS
N151- Total pancreatectomy and autologous islet transplantation	Garcea Giuseppe	CHUGGS
N148- Vascular Resections in Pancreatic Cancer	Garcea Giuseppe	CHUGGS
N147- Laparoscopic para-aortic lymphadenectomy	Chattopadhyay Supratik	W&C
N146- Superior semicircular canal dehiscence repair	Baruah Paramita	MSS
N143- Middle Ear Implants	Baruah Paramita	MSS

Ref Title	Clinical Lead	CMG
N131- Hysteroscopic Tubal Cannulation (HTC)	New Clinical Lead Pending	W&C

2.8 Six notifications were “suspended due to no activity in the past 12 months.” NIPAG had previously approved these procedures, but over the course of the year, there have been very low numbers, or no cases were completed.

Suspension in this context is an administrative and governance step — not necessarily a permanent cancellation — and occurs for one or more of the following reasons:

- Lack of patient cases
- The procedure might be very specialised, and no suitable patients were enrolled during the year.
- Operational or resource constraints
- Strategic or clinical changes
- New evidence, guidance updates, or shifts in clinical priorities may have lessened the need for the procedure.
- Awaiting further readiness

2.9 **What does suspension mean in practice?**

The procedure remains on record but is not actively authorised for use.

If a team wants to recommence the procedure, they must re-notify NIPAG — providing updated rationale, evidence, and governance documentation.

This prevents procedures from being “quietly” dormant on the audit list without oversight.

2.10 Table 4 below shows the six notifications that were suspended in 2024/2025 due to low or no activity in the past 12 months.

Table 4

Ref Title
N137 - MR-Transrectal Ultrasound Fusion Biopsy
N138 - Autologous Retinal Transplantation for Degeneration Pigment Advanced Epithelium Exudative and Choroidal Graft Age-Related Macular
N150 - Administration: of intraventricular chemotherapy via an Ommaya reservoir
N155 - Highlife Study (research) percutaneous catheter procedure to replace mitral valve via transvascular and transseptal approach
N156 – LimFlow- Minimally invasive medical device designed to treat Chronic Limb-Threatening Ischaemia.
N158 - EUS guided RFA for Pancreatic Cancer (including Neuroendocrine tumours)- Minimally invasive procedure used to treat pancreatic neuroendocrine tumours.

2.11 Table 5 below shows the three notifications that were closed and completed for routine use in 2024/2025, which reflects that the new interventional procedures have:

- Completed the full approval and audit process — from initial notification, through active monitoring and outcome review.
- Met all governance, safety, and performance criteria set by NIPAG and, where applicable, NICE.
- Been deemed safe, effective, and appropriately embedded into standard clinical practice within UHL.

Once a procedure reaches this stage, it no longer requires NIPAG oversight and is an established treatment offered by the Trust.

Table 5

Ref Title	Clinical Lead	CMG
N169- Percutaneous Image Guided Microwave Ablation Of Liver Cancer	Ahmad Rosemina	CSI
N165- Rezum	Rai Jaskarn	CHUGGS
N133- Mitraclip	Kovac Jan	RRCV

2.12 NIPAG is responsible for overseeing compliance with NICE Interventional Procedure Guidelines for UHL (IPGs). NICE regularly publishes or updates IPGs, which provides guidance on the safety, efficacy, and conditions for using specific interventional procedures. Each year, NIPAG reports to the Trust:

- Number of applicable IPGs
- Compliance status (Compliant, Partially Compliant, Awaiting Assessment).
- Non-compliance or partial compliance triggers follow-up actions, such as training, pathway changes, or further audit.

2.13 Table 6 presents a review of compliance responses received regarding 19 NICE Interventional Procedure Guidance (IPGs) received in 2024/25.

Table 6

Title	Ref	Response	
		Applicability	Compliance
Alcohol-mediated perivascular renal sympathetic denervation for resistant hypertension	IPG801	N/A	N/A
Intravascular lithotripsy to treat calcified coronary arteries during percutaneous coronary intervention	IPG802	Applicable	Compliant
Electrically stimulated intravesical therapy for interstitial cystitis or overactive bladder in adults	IPG799	N/A	N/A
Transperineal laser ablation for treating lower urinary tract symptoms of benign prostatic hyperplasia	IPG798	N/A	N/A
MRI-guided focused ultrasound thalamotomy for treating moderate to severe tremor in Parkinson's	IPG796	N/A	N/A
MRI-guided focused ultrasound subthalamotomy for treating Parkinson's	IPG797	N/A	N/A
Direct skeletal fixation of limb prostheses using an intraosseous transcutaneous implant	IPG795	N/A	N/A
Endoscopic bipolar radiofrequency ablation for malignant biliary obstruction	IPG794	N/A	N/A
Single-step scaffold insertion for repairing symptomatic chondral knee defects	IPG793	N/A	N/A
Phrenic nerve pacing for congenital central hypoventilation syndrome	IPG790	Partially	Compliant

Title	Ref	Response	
		Applicability	Compliance
Caval valve implantation for tricuspid regurgitation	IPG791	Awaiting	Awaiting
Phrenic nerve pacing for ventilator-dependent high cervical spinal cord injury	IPG792	Awaiting	Awaiting
Minimally invasive percutaneous surgical techniques with internal fixation for correcting hallux valgus	IPG789	N/A	N/A
Endoscopic duodenal mucosal resurfacing for insulin resistance in type 2 diabetes	IPG787	N/A	N/A
Image-guided percutaneous laser ablation for primary and secondary liver tumours	IPG788	Awaiting	Awaiting
Selective internal radiation therapy for neuroendocrine tumours that have metastasised to the liver	IPG786	N/A	N/A
Lymphovenous anastomosis during axillary or inguinal node dissection for preventing secondary lymphoedema	IPG785	N/A	N/A
Epidermal radiotherapy using rhenium-188 paste for non-melanoma skin cancer	IPG784	N/A	N/A

2.14 The NIPAG Annual Report 2024/25 highlights continued dedication to strong governance and clinical oversight for the introduction and monitoring of new interventional procedures in the Trust. The Committee has a robust review process, ensuring patient safety, clinical effectiveness, and adherence to NICE guidance. Through the NIPAG process, interventional procedures to benefit patient care have been successfully integrated into routine practice. New procedures are subject to active audit to provide assurance prior to becoming routine procedures. NIPAG remains a crucial mechanism for innovation and quality assurance in clinical care. The report assures that new procedures are being implemented responsibly and transparently, with robust follow-up and governance.

END OF REPORT

Paper H3

Meeting title:	Quality Committee
Date of the meeting:	28 August 2025
Title:	Infection Prevention Annual Report 2024/25
Report presented by:	Elizabeth Collins Head and Deputy Director of Infection Prevention
Report written by:	Elizabeth Collins Head and Deputy Director of Infection Prevention

Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously	Trust Infection Prevention Assurance Committee Meeting (TIPAC) 28.7.25					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Provide assurance

Impact assessment
None to date

Acronyms used:
TIPAC Trust Infection Prevention Assurance Committee
UHL IP BAF Infection Prevention Board Assurance Framework
UKHSA United Kingdom Health Security Agency
IPT Infection Prevention Team
IP Infection Prevention
CQC Care Quality Commission
NHSE National Health Service England
NCS National Cleaning Standards
CMG Clinical Management Groups
MRSA Meticillin Staphylococcus Aureus
CDT Clostridioides difficile toxin
E.coli Escherichia coli
HOHA Hospital onset hospital associated
COHA Community onset hospital associated
COIA Community onset indeterminate association
COCA Community onset community associated
PPE Personal Protective Equipment
FFP3 Face filtering Piece
PLACE Patient Led Assessment of the Care Environment
WSG The Water Safety Group
AE Authorising Engineer

Purpose of the Report

Present the 2024/25 Infection Prevention Annual Report

Recommendation

The committee is asked to receive this report and to note the work load and effort of the Infection Prevention Team during the past year.

Please note the committee is also asked to note that a separate Estates and Facilities, Cleaning and Soft Service Annual Report 2024/25 will be presented separately at the end of Q2 2025/26

Summary

The Committee is asked to note in particular the work load and efforts of the Infection Prevention Team during the past year which includes continuing to implement a Board Assurance Framework which has been recognised as an exemplar by NHSE.

The establishment of the Mask Fit Testing Service continues. This is providing a cost effective service to the organisation which is a mandatory requirement for UHL.

Developing a process for and managing the increase in cases of Measles presenting to and identified within UHL

The continued development of the UHL Surgical Site Infection Surveillance Programme which has been recognised as an exemplar and whilst this does not relate specifically to the year 2024/25, evidence and data has been shared with the CQC at their recent inspection in support of governance, quality and patient safety within UHL

The team continues to respond to all actions that have been required of it, and proactively supports all CMGs and UHL teams in managing healthcare associated infections and on-going respiratory infections.

Main report detail

University Hospitals of Leicester NHS Trust

Infection Prevention Annual Report

2024/2025

Infection Prevention Annual Report

April 2024 - March 2025

Contents

1. Executive Summary

This Report reviews the 2024/25 Infection Prevention successes and challenges for UHL.

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

Quarterly reporting to the Trust Infection Prevention Assurance Committee throughout 24/25 was revised and now uses a slide deck presentation. This was in order to accommodate a large amount of information in an easier to read format. This Annual Report however continues to use a narrative presentation to further support effective governance and assurance with regard to Infection Prevention management within UHL.

UHL Infection Prevention Board Assurance Framework (IPBAF) continues to be strengthened in content. As it is developed, it has proved to be an effective tool for data capture at ward and department level, indeed it has been recognised by NHSE as an effective tool for IP management and we have been commended for this.

Respiratory virus management and containment systems and processes in line with national instructions continued to be instigated throughout 2024/25.

UHL is required to report onto the United Kingdom Health Security Agency data capture system the following organisms:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Methicillin-sensitive *Staphylococcus aureus* (MSSA)
- Gram negative Bloodstream Infections (BSI)
- *Clostridioides difficile* (C. difficile)

The growth of the Surgical Site Infection Surveillance (SSI) programme continues at pace now and a full report is available and will be presented to the UHL Quality Committee. The Trust is now in the best position it has ever been with regard to beginning to identify infections post operatively in certain speciality groups. This moves UHL into a position of being an exemplar in this field and most importantly directly supports the provision of a quality and safer service for our patients. There is further detail later in this document

Mandatory Mask Fit Testing for the protection of our staff continues and after significant work by the UHL Fit Testing Team, the Trust again is in the best position it has ever been in with regard to being able to understand compliance with this directive and importantly offer protection to our staff.

2. Introduction

This report provides the Trust Board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention Team between April 2024 and March 2025. The publication of the Infection Prevention (IP) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare Associated Infections (HCAIs). We strive to ensure that good IP practices are applied consistently and are part of our everyday practice, meaning that people who use UHL services receive safe and effective care.

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical, which play a vital role in improving the quality of patient and stakeholders experience as well as helping to reduce the risk of infections.

The legacy of the COVID pandemic continues and has exposed weaknesses across the NHS, including the defects in the structure and function of buildings, staff shortages, incomplete national planning for pandemics and lack of adequate social care facilities in particular. We regret the COVID and other respiratory infections acquired by some patients in hospital despite the best efforts of colleagues across the organisation to keep all of our patients safe. Lack of adequate numbers of single en-suite facilities within the acute Trust and social care facilities within the community has led to more patients remaining in acute sector hospitals for much longer than is required, therefore exposing them to the risk of Hospital/ Healthcare Associated Infection (HCAI)

The UHL Infection Prevention Team (IPT) is committed to identifying and highlighting these weaknesses, redoubling efforts begun before the pandemic to work with colleagues at every level to improve the quality of NHS estate, resources and practice locally and nationally. The IPT is dedicated to providing a service that treats all patients equitably, making sure that patients from frequently underserved communities and backgrounds receive high quality care. Working with all colleagues across the organisation has ensured that there has been on-going emphasis given to the implementation of National directives, guidance documents and the prevention of healthcare associated infection and I would like to thank the team for being truly reactive and responsive to challenges presented to them on an almost daily basis and for their unswerving support.

Elizabeth Collins, Head and Deputy Director of Infection Prevention

University Hospitals of Leicester

3. UHL Governance and Assurance Framework

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

The Trust Infection Prevention Assurance Committee (TIPAC) continued during 2024/25 and received reports and updates from the Infection Prevention Team and wider allied groups within UHL.

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

Adherence to National policy and guidelines continued to be implemented through a dedicated Infection Prevention multi-disciplinary Trust Infection Prevention Operational Group (TIPOG) with fortnightly meetings and has been formally adopted as a sub group of the Trust Infection Prevention Assurance Committee.

This meeting is used to communicate operational guidance and issues relating to Infection Prevention, including cleaning and decontamination, PPE, vaccination, staff and patient testing, and occupational health. It is also useful as a forum for staff to be able to express concerns and provide opinion on local guidance. Information shared is taken forward into staff safety huddles for onward communication.

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

A comprehensive assurance reporting framework remained in place.

The Infection Prevention arrangements within the CMGs are reported and confirmed at the CMG Quality and Performance Management Committees and ultimately by exception to the Trust Infection Prevention Assurance Committee and then into the Quality Committee. Executive meetings have been reviewed across the organisation.

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

The programme of work is mapped to the duties of The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2022) and incorporates elements of the Trust Commissioning Quality Schedule (where applicable) UHL Quality Commitment, National Institute for Clinical Excellence (NICE) guidelines and any relevant recently produced national guidance documents.

Throughout 2024-2025 the IPT continued to engage in the Monthly Integrated Performance Reviews on HCAI performance (including MRSA and *C.difficile* rates). These are produced and presented to the Quality Committee and quarterly Infection Prevention reports are produced by all CMGs which are presented to TIPAC

The Director of Infection Prevention and Control provided the direct link to the Trust Leadership Team with issues, by exception.

3.1 Infection Prevention Board Assurance Framework

During 2024/25 the Infection Prevention Team concentrated on implementing The National Infection Prevention and Control Board Assurance Framework, published by NHSE. This framework enables organisations to use an evidence based approach to maintain the safety of

patients, service users, staff, and others. Used by all those involved in care provisions in England and can be used to provide assurance in NHS settings.

National-infection-prevention-and-control-board-assurance-framework.xlsx (live.com)

UHL has adopted this framework and renamed it UHL Infection Prevention Board Assurance Framework (UHL IP BAF) in order to provide an assurance structure for the Trust Board. It has been devised to enable transparency from ward to board in regards to the level of compliance against the Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and related guidance (2022). All Ward/Department Leaders across all services delivered at UHL are engaged in the UHL IP BAF and are accountable for their documented level of compliance.

The level of compliance at Ward/Department or service through to CMG and department is monitored robustly through the TIPOG meetings with exceptions escalated to TIPAC accordingly.

This assurance process has gone from strength to strength throughout the year of 2024- 2025 with more areas and services that have come on board with the UHL IP BAF, to gain a better understanding of the Health and Social Care Act and code of practice but to also assess their level of Infection Prevention compliance and how they can address those areas of concerns.

4. Leicester, Leicestershire and Rutland (LLR) Monitoring Framework

NHS Commissioning of services for Leicester, Leicestershire and Rutland is now undertaken through an Integrated Care System (ICS). All parts of the NHS, as well as other partners such as local authorities and the voluntary and community sector, take on greater responsibility for working together and collectively managing resources. They aim to improve the health of residents by preventing illness, tackling inequalities and unwarranted variation in care, whilst delivering seamless services.

Currently Infection Prevention advice to the ICS is provided by 2 IPN employed directly by them.

The ICS IPN participates in the post infection reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also receive an overview of the cases of UHL CDI.

Infection Prevention across LLR was strengthened during the pandemic, during 2024/25 saw the development of an Infection Prevention and Control Community of Practice group. The remit of this group is to harmonise the approach and share good working practices to Infection Prevention, working together to ensure the delivery of standardised patient care across the county.

5. Care Quality Commission Regulation

The Code of Practice: *The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance* applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers. The code of practice document was updated on 13 December 2022 to reflect changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of Infection Prevention and control (IPC) to include cleanliness and optimising antimicrobial use and reducing antimicrobial resistance. The new document takes account of changes to the IP landscape and nomenclature that have occurred since the COVID-19 pandemic.

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

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

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Table 1; *Compliance Criterion*

A copy of the CQC compliance reports for Leicester Hospitals is available on the UHL public and CQC websites. There were no formal CQC inspections of UHL within the end of March 2024 and the beginning of April 2025

6. Infection Prevention Within UHL

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

6.1 Infection Prevention Team

Head and Deputy Director of Infection Prevention (HDDIP).	Whole Time Equivalent Posts
Deputy Lead Infection Prevention Nurse (DLIPN)	x1 WTE
Senior IPNs	x 2 WTE
Specialist IPNs	x 6.2 WTE
IPN	x 4
CDI Specialist Nurse	x1
Surveillance Assistants	X3
Senior Information Analyst	X1
Data Information analyst	x1
MFT Manager and Personal Assistant to HDDIP	x1
Infection Prevention Administration co-ordinator	x1
Mask Fit Testers	x6

Table 2: *Infection Prevention Team (IPT)*

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

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

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

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

- Providing advice on all aspects of Infection Prevention ensuring that UHL meets the requirements of The Health and Social Care Act (2008) Code of Practice for the Prevention of Healthcare Associated Infections
- Closely monitoring Microbiology results via the electronic reporting system to enable robust and timely patient management
- Managing outbreaks of infection
- Managing incidents that relate to Infection Prevention

- Improving Infection Prevention capability and capacity within Clinical Management Groups
- Developing and facilitating programmes of education and training
- Undertaking audit and developing a targeted surveillance programme where possible
- Formulating policies and procedures
- Interpreting and implementing national guidance at a local level
- Involvement with new building and equipment projects

There is an ever diminishing pool of Infection Prevention Specialists nationally, for which all organisations now compete.

Infection Prevention is a specialism which requires study as described previously at not only a basic level, but has the opportunity to follow an extensive educative career pathway in both the practical application of this subject and also research. Specialist Infection Prevention courses are best taken after staff have 'hands on experience' of at least a year. Education and training of our new Infection Prevention staff is ongoing as we develop our own Specialist Nurses. Within UHL we then encourage our colleagues to undertake further academic training courses offered by various Universities in England.

One of the Senior Infection Prevention Matrons has developed a program of learning for the differing staff groups amongst the team as well ensuring collective learning for the team as a whole. The IP matron has regular one to one reviews with our new starters to support their integration into the team and into UHL as well as their health and wellbeing. Feedback from our new team members is extremely positive with regard to the support, education and training they have been given by the whole team and we are delighted to welcome them and look forward to supporting their career development

6.2 Education and Quality Improvement

The IPT provide an extensive multi-modal programme of Infection Prevention education across the trust to support compliance with mandatory training and national guidance

In addition to this IP education is provided in response to data collection, identified need or upon request.

During 2024/25 119 ‘face to face’ taught training sessions were delivered. The IPT have also continued to deliver Infection Prevention training to International Nurses, Trainee Nursing Associates, Medical Students, Health Care Assistants, Midwifery Care Assistants, Theatre Support, Doctors local inductions, Surgical Practise Course, High Consequence Infectious Disease buddy Training, Hand hygiene and PPE audit training. These taught sessions vary in length of delivery from 20 minutes to 4 hours.

These training sessions have been well received and the feedback is positive for content, style and pace of delivery.

The IPT has also delivered approximately 109 CMG based training sessions in the clinical areas which all vary in length of time and topic but included: Viral Haemorrhagic Fever training, link staff training and decontamination training.

We took the opportunity to review patient information leaflets which are now all up to date and are popular downloads, as well as producing a monthly Infection Prevention newsletter for staff on various topics which is disseminated and communicated to every CMG.

During 2024/25 the Infection Prevention intranet pages were also completely reviewed to ensure information and guidance on the new Trust ‘Connect’ pages is correct and up to date

These figures do not include locally delivered education by individual IP nurses who have provided a blend of in situ and virtual Infection Prevention training within their own CMG.

Quality Improvement is an integral part of the Infection Prevention role and whilst there is always competing priorities for the whole team, a collaborative effort by the IPT has again determined that, the lack of face to face Infection Prevention education contributes to the incorrect use of PPE and a reduction in compliance with hand hygiene.

The focus for 24/25 was;

- To support increased compliance with Aseptic Non-Touch Technique this is a vital element of healthcare practise for the prevention of skin/wound or blood stream infections.
- Support the development and implementation of digital forms for the recording of vascular access interventions
- Support the revision of Cannulation packs which are widely used throughout the organisation to ensure they remain cost effective, fit for purpose and support effective clinical practise contributing to the reduction of blood stream infections

The Compliance with the 5 moments of hand hygiene is always variable for many different reasons within any healthcare facility and UHL is no different, whilst there was some improvement noted during 2024/25 this simple practise continues to present as a challenge from an educational perspective.

7. Mask Fit Testing Service

The Mask Fit Testing service was implemented in-house towards the end of 2023. The Mask Fit Testing service manage and oversee the programme of FFP3 (Filtering Face Piece) mask fit testing across UHL under the responsibility and the reporting structure of the Infection Prevention Team at UHL. This is a mandatory requirement of organisations outlined by the Health and Safety Executive.

The MFT service continues to provide a responsive mask fit testing service for staff, working towards ensuring that UHLs staff are appropriately mask fit tested and any gaps identified and the necessary actions are taken.

The MFT service continues to provide MFT sessions across the 3 hospital sites which are bookable via HELM.

The Roving service is available for CMGs and is bookable with the MFT Team

Mask Fit Testing has been added to HELM as essential to job role. This is to increases UHL compliance with mask fit testing for staff.

Challenges:

- Medical engagement in MFT
- Staff non-attendance at booked sessions
- Issues remain with wards releasing staff
- Engagement of CMGS in the roving service

The Trust wide compliance (inclusive FFP3 and Respirator Hoods) is 52.60%

8.54% of staff requires a respirator hood

The table below shows the total number of Mask Fit Testing sessions offered during 2024/25 showing the breakdown of the number of staff passed on an FFP3 and the staff required to wear a respirator hood

Quarter	Number of Session Offered on HELM	Attendance				FFP3 & Respirator Hood Compliance		
		Total number of sessions booked on HELM	Number of People Attended session	Number of People Did Not Attend session	Sessions Available but Not Booked	No of Staff passed on FFP3	Staff require hood due to non compliant with FFP3	Staff require Hood due to facial hair
Q1	2213	1426	1105	321	787	848	192	66
Q2	1780	1102	867	235	678	650	169	56
Q3	2023	1637	1236	401	386	955	155	126
Q4	1221	828	599	229	393	526	42	31
Total	7237	4993	3807	1186	2244	2979	558	279

Table 3: *FFP3 attendance tracking for 2024/25*

7.1 Respirator Hoods and Powered Air Purifying Respirators (PAPR)

During Q4 2024/25 the MFT team have been working throughout UHL to collate and to provide full working PAPR units for staff.

An options paper was presented to Trust Infection Operational Group (TIPOG) in February 2025. The options were considered and discussed and it was agreed no further purchasing of PAPR equipment would be undertaken until a robust gap analysis had been undertaken to consolidate current equipment. These would then to be centralised with oversight, management and maintenance carried out by the Mask Fit Testing team.

This is in line with ensuring the organisation has a robust understanding of the equipment it has purchased and this remains fit for purpose, in full working order, is being managed effectively and unnecessary expenditure is kept to a minimum.

All equipment was collected from across the CMGs to consolidate the equipment and create full working units/kits, with the exception of ITAPS, CSI, ED, Resus and IDU as they have good stewardship within these areas and will continue to manage the PAPR equipment. A total of 63 full kits have been identified. A further 36 kits are to be stored with Medical physics and loaned out to CMGS, the loan process is being worked up and finalised, this will be communicated through TIPOG and communications. A further 6 PAPR kits will be created, and provided to TACTICAL Command across the 3 sites for out of hours access.

7.2 Next steps

- Medical physics to add the units/kit to the database and the full PAPR kits will be located with Medical Physics across the 3 sites
- Clear Communication to be drafted and circulated to staff regarding the process for the PAPR kits
- Provide Assurance report to TIPAC Q4
- Further kits can be made from the items / equipment collected from wards / areas, the final number to be confirmed

8. Infection Prevention Link Staff (IPLS)

There is a robust IPLS training programme that can be successfully delivered by the IPT, which normally includes quarterly training days as well as individual support and workplace advice. The content of the programme is continually reviewed to ensure that it is reflective of current practice and supports the Link Staff to remain current and up to date. The team have also explored other multi model methods of delivery to maintain engagement and enthusiasm of the Link Staff, acknowledging other competing training programmes and service delivery challenges.

9. Healthcare Associated Infection Surveillance

The Infection Prevention Team (IPT) undertakes continuous surveillance of alert organisms and alert conditions using Nervecentre (our next generation electronic system partners). This system has been developed within UHL in collaboration with our IT System partners and we continue to work with them to further develop the programme.

9.1 Alert Organisms[1]

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

9.2 Alert Conditions

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

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

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

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

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

9.3 Mandatory Surveillance of Surgical Site Infections (SSI)

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

In 2024/25, UHL submitted data for knee replacement surgery for quarters 1, 2, 3 and 4.

9.4 Surgical Site Infection Surveillance Programme

The Surgical Site Infection (SSI) programme commenced in December 2022 with initial data collection focusing on Cardiac, Spinal, and Hepato-Pancreato-Biliary (HPB) surgeries. However, during the summer of 2023, the team was significantly impacted by a loss of staff due to unforeseen circumstances—including the unexpected death of a team member, an unanticipated resignation, and an internal promotion. As a result, the latter half of 2023 and early 2024 was primarily dedicated to recruitment and rebuilding the team.

Since re-establishing the team in 2024, the programme has expanded surveillance efforts to include additional surgical areas, specifically:

- Hysterectomy
- Caesarean Section
- Bowel surgery
- Breast surgery

Data collection follows the framework set out by the UKHSA Surgical Site Infection Programme, including 30-day postoperative follow-up. Information is obtained from both digital and paper-based records and is structured around the preoperative, intraoperative, and postoperative phases. To ensure accuracy and clinical relevance, all identified cases are reviewed and validated by a clinician. Analysis incorporates this data along with reference to the following national guidelines:

- NG125: Surgical Site Infections: Prevention and Treatment
- MG50: Use of Triclosan-Coated Sutures

Additionally, the team has integrated 65 structured observations using the nationally recognised *One Together* Toolkit. This tool supports the reduction of surgical site infections by assessing adherence to best practice through observational audits.

Three task and finish groups were originally formed around the Cardiac, HPB, and Spinal data. While these streams have continued into 2024 to some extent, it became clear that the broader dataset emerging from the additional surgical areas was more suitable for informing a Trust-wide approach. Consequently, an overarching strategy for SSI reduction at University Hospitals of Leicester (UHL) was adopted.

Given the operational pressures during the winter period, a seminar was scheduled for June 2025 to present and discuss baseline surveillance data from across UHL. This included both internal and external audit findings. Leading up to the seminar, preliminary findings have been presented at various clinical specialty meetings, where discussions around the programme and its implications have taken place.

At this stage, we have established robust baseline data and developed a clearer understanding of key contributing factors to SSIs. Some of these factors can be mitigated through improved clinical practice and enhanced knowledge. Others, particularly those relating to patient optimisation, require broader discussions across the Leicester, Leicestershire, and Rutland (LLR) healthcare community.

Whilst this report relates to 2024/25 it is relevant to outline the seminar in June 9th seminar, as this is materially important to the actions going forward. The plan is to engage directly with Clinical Management Groups (CMGs) to address modifiable risk factors through targeted education, competency building, and skills development. It is anticipated that the Infection Prevention Team (IPT) will host biannual seminars going forward to share progress, learning, and outcomes.

The SSI programme at UHL has also garnered interest from various external stakeholders. Anecdotally, our holistic approach—including comprehensive record review, observational audits, and proactive clinical engagement—has been recognised as a model of best practice.

We have been approached by:

- **Essity**, a wound care company whose *Leukomed Sorbact Dressing* is now recommended as the first-line primary dressing for Caesarean sections (MG55), to conduct a trial of their product in Breast and HPB surgery.
- **Johnson & Johnson MedTech**, manufacturers of Triclosan-Coated Sutures, who have expressed interest in our pre- and post-implementation data from cardiac surgery.

We are also partnering with **ISLA Health**, developers of a digital post-operative wound surveillance app, to explore expanding their platform beyond wound care to cover the entire perioperative patient pathway

There is a detailed SSI report available and this will be presented to the UHL Trust Infection Prevention Committee and the Quality Committee

9.5 MRSA and MSSA Prevention and Reduction Strategies

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

The UHL threshold for MRSA bloodstream infections for 2024/25 was 0 avoidable cases. The Trust recorded 4 Hospital onset Healthcare Associated (HOHA), 6 Community onset, Healthcare Associated (COHA) case for 2024/25.

The implementation of measures, in recent years, designed to further reduce the numbers of cases of MRSA bacteraemia within UHL and these have continued during 2024-2025 however given the number of cases that have been identified a review of the MRSA policy and all actions pertaining to the prevention of infection with this organism will be reviewed during 2025/26

There is absolutely no room for complacency with regard to our drive to prevent acquisition of infection within the hospitals. As these numbers become smaller, there will inevitably be a

threshold beyond which a continued reduction will not be possible. Sustained management of systems and processes instigated in previous years will be crucial to our continued success and our teams work hard to maintain these low infection numbers.

9.6 Clostridioides difficile Prevention and Reduction Strategies

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

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

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

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

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

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

Episodes are reported via the UKHSA mandatory enhanced surveillance system.

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

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

Acute provider objectives are set using these two categories:

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

Reference: Clostridium difficile infection objectives for NHS organisations in 2023/24 and guidance on the intention to review financial sanctions and sampling rates from 2023/24.

	April	May	June	July	August	September	October	November	December	January	February	March	Total
CDIFF NHSE Threshold 24/25	13	14	14	14	14	14	14	14	14	14	14	14	167
* Actual Infections (HOHA)24/25	7	10	7	16	14	18	15	13	15	9	3	6	133
* Actual Infections (COHA) 24/25	9	5	5	9	3	7	5	10	6	6	6	7	78
* Actual Infections Total (HOHA & COHA) 24/25	16	15	12	25	17	25	20	23	21	15	9	13	211

Table 4: *The monthly number of Clostridium difficile reportable infections 2024-2025*

Isolating each patient with *C.difficile* diarrhoea continues to be a priority, to prevent cross contamination. Patients with *C.difficile* are cared for in single rooms. Where patients were not isolated it was for over-riding clinical reasons in the vast majority of cases (e.g. on an Intensive Care Unit).

It is recognised that it is important to continually monitor and reinforce the messages to staff with regard to HCAI's. The Department of Health published guidance entitled '*Clostridium difficile* - How to deal with the problem' in early 2009. UHL has implemented this guidance across the Trust and a dedicated CD Liaison Nurse works across the three sites and continues to work with the Infection Prevention Team to ensure appropriate management of these patients and to provide specialist support to nursing and medical colleagues.

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

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

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

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

A review of all actions in relation to CDI will be undertaken in 25/26 to ensure everything that should be being undertaken within UHL to prevent this infection is being carried out.

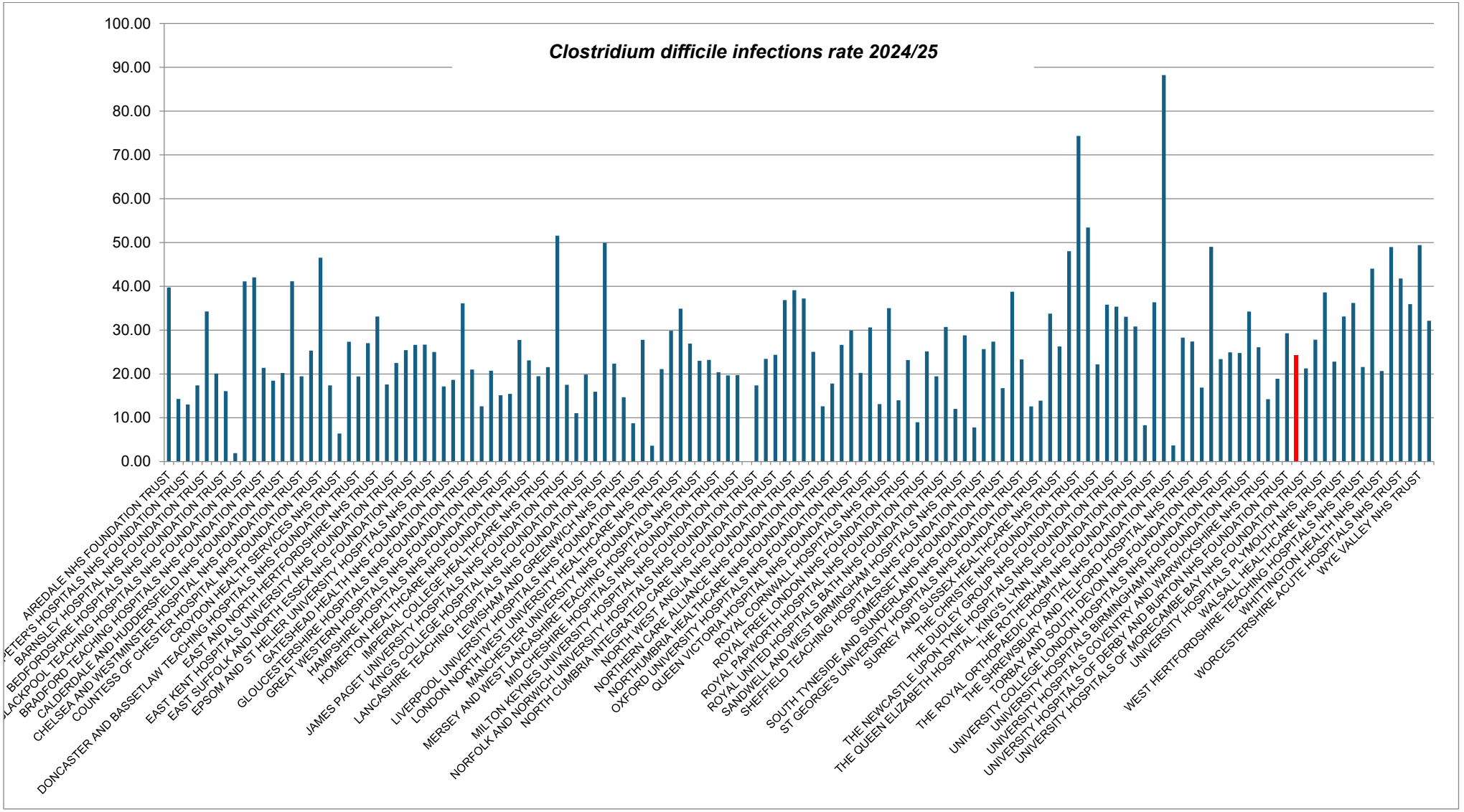


Table 5: *Hospital onset- hospital associated Clostridium difficile infections rate by financial year per occupied overnight beds (per 100,000).* (source UKHSA). UHL highlighted in red.

9.7 Gram Negative Blood Stream Infections

There was a National ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2024. There was no forthcoming guidance as to how this might be achieved or supported by organisations or any funding forthcoming for this. As previously indicated we continued to collect the alert organism data and report this to the Data Capture System (DCS) at United Kingdom Health Security Agency (UKHSA).

These can be serious infections and often result in admission to critical care and in some cases mortality. We know GNBSI cases can occur in hospitals however, half of all community onset cases have had some healthcare interventions either from acute, primary or community care. Therefore, we can only achieve the reductions by working together across the whole health and social care sector.

As part of the UHL Patient Safety Incident Response Framework (PSIRF) the IPT have been reviewing our approach to Infection Prevention reviews and incidents. This has enabled us to begin the review of all identified blood steam infections in collaboration with ward based colleagues, with the aim of understanding acquisition of these organisms and what actions may be taken to prevent this in our healthcare setting

The Head and Deputy Director of Infection Prevention and Lead Infection Prevention Dr have written an Infection Management Strategy for the ICB and across LLR.

This seeks to support understanding of the development of these infections and actions required to mitigate, reduce, and prevent these where possible

Work has now commenced to implement this strategy

9.8 E coli (*Escherichia coli*) Bacteraemia

E coli is the leading cause of Gram Negative Blood Stream Infections (GNBSIs) and in accordance with the Department of Health (DH) Guidelines the IPCT undertakes mandatory reporting of identified cases.

	April	May	June	July	August	September	October	November	December	January	February	March	Total
E-Coli NHSE Threshold 24/25	14	14	14	14	14	14	14	14	15	15	15	15	172
*** Actual Infections (HOHA)24/25**	4	10	13	9	8	9	9	7	8	9	11	8	105
*** Actual Infections (COHA) 24/25**	8	5	6	4	8	10	9	8	9	8	5	8	88
*** Actual Infections Total (HOHA & COHA) 24/25**	12	15	19	13	16	19	18	15	17	17	16	16	193

Table 6: *The threshold for 2024/25 for E.Coli BSI 172, Actual Gram-negative blood stream infections reported in 2024/25 for E.Coli BSI were 193, 105 (HOHA), 88 (COHA)*

9.9 Pseudomonas BSI

	April	May	June	July	August	September	October	November	December	January	February	March	Total
Pseudomonas NHSE Threshold 24/25	3	3	3	3	3	3	3	3	3	3	4	4	38
*** Actual Infections (HOHA)24/25**	2	1	2	2	4	3	6	4	1	1	0	0	26
*** Actual Infections (COHA) 24/25**	2	1	0	1	0	1	0	0	1	1	0	1	8
*** Actual Infections Total (HOHA & COHA) 24/25**	4	2	2	3	4	4	6	4	2	2	0	1	34

Table 7: *The threshold for 2024/25 for Pseudomonas BSI 38, Actual Gram-negative blood stream infections in 2024/25 for Pseudomonas BSI were 34, 26 (HOHA), 8 (COHA)*

9.10 Klebsiella sp. BSI

Year	April	May	June	July	August	eptembe	October	Novembe	December	January	February	March	Total
Klebsiella NHSE Threshold 24/25	7	7	7	7	7	7	7	7	7	7	8	8	86
*** Actual Infections (HOHA)24/25**	6	0	9	10	6	6	5	6	3	7	8	8	74
*** Actual Infections (COHA) 24/25**	1	2	4	4	2	1	5	1	1	5	6	3	35
*** Actual Infections Total (HOHA & COHA) 24/25**	7	2	13	14	8	7	10	7	4	12	14	11	109

Table 8: *The threshold for 2024/25 for Klebsiella sp. BSI 86, Actual Gram-negative blood stream infections reported in 2024/25 were Klebsiella sp. BSI 109, 74 (HOHA), 35 (COHA).*

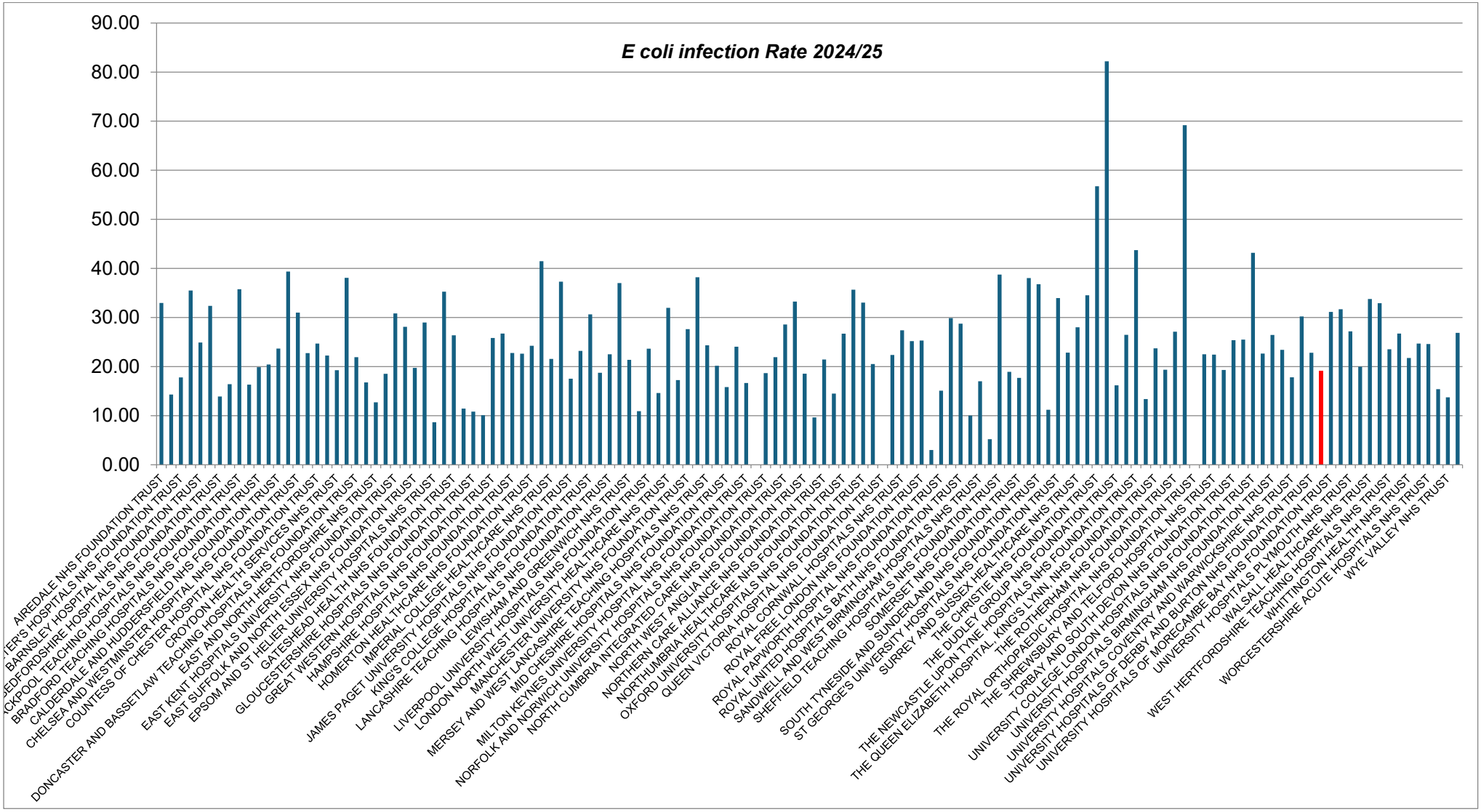


Table 9: *Hospital onset - hospital acquired apportioned E coli infections by financial year (2024/25) per occupied overnight beds (per 100,000).* (source UKHSA). UHL highlighted in red.

9.11 Carbapenem Resistant Enterobacterales/Extensive Drug Resistance

Guidance by the United Kingdom Health Security Agency (UKHSA) for the above predominantly concentrates on prevention: isolation of high-risk individuals with screening being of particular importance. The UHL focus is to identify, isolate, investigate, inform and initiate (the i5's of Infection Prevention) management of these patients and all patients that fit specific screening criteria are screened for these organisms. This enables identification and management of these patients to prevent further transmission.

Carbapenem Resistant Enterobacterales (CRE) typically colonises well patients but can present a threat when they become a systemic infection. They are clinically important because they are resistant to most antibiotics and so exceedingly difficult to treat. In addition, while some antibiotics remain effective treatment, these are very expensive drugs, costing up to £450 per patient per day. CRE are a global phenomenon for which there is a policy and management protocol well established within UHL.

Historically Environmental sampling has provided evidence of the potential for environmental transmission within wards. The importance of a robust cleaning standard and a reactive maintenance process are extremely important in the prevention of spread of these organisms.

10. Outbreaks of Infection and Incident Reports

UHL continued to instigate formal outbreak management processes where outbreaks of Infections were identified throughout 2024-25.

In accordance with UKHSA Guidance an outbreak or incident may be defined as:

- an incident in which 2 or more people experiencing a similar illness are linked in time or place
- a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- a single case for certain rare or high-consequence diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio
- a suspected, anticipated or actual event involving microbial contamination of food or water

These events are recognised through surveillance, reporting or routine IP activities and are by definition unpredictable. UHL have the support of the informatics team whereby there is an automated process by which patient infection numbers are reviewed and analysed on a daily basis according to the nationally defined criteria and apportionment of the onset model.

Infection Prevention incidents may not always relate directly to infection but be the consequence, where further investigation is required. If this has an operational impact then this in itself can be enough to trigger an incident response requiring a multi-disciplinary focus.

Every year the Infection Prevention Team recognises and responds to many incidents and potential outbreaks. Some are of significance. However others turn out to be

chance clusters not caused by cross infection. The Infection Prevention Team has to be alerted to all potential outbreaks.

In the event of a suspected outbreak, NHS organisations were to follow an updated UKHSA guidance, Communicable disease outbreak management: operational guidance Communicable disease outbreak management: operational guidance - GOV.UK (www.gov.uk)

For each outbreak an 'outbreak/incident control team' is required key colleagues from the relevant CMG, laboratory, estates and facilities, as well as colleagues from NHSE, UKHSA and the ICB are considered to attend a meeting to which all minutes and action logs were kept. Senior Leadership at all outbreak/incident meetings was provided by the Chief Nurse/Deputy Chief Nurse or the Lead Infection Prevention Nurse

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

Where an outbreak or incident is considered to be particularly significant because of its size or the lessons learnt, this is managed as a Patient Safety Incident Investigation (PSII) and reported in line with the NHS Patient Safety Incident Response Framework (PSIRF)

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

After an outbreak/incident, the IPT support the development of a report which is presented to the CMG IP groups and TIPAC.

At a Leicester, Leicestershire and Rutland (LLR) level all organisations providing NHS services meet on a weekly basis to discuss the local infection status.

During 2024-25 75 outbreaks of COVID/CRO/Norovirus, have been managed by the IPT in line with the UKHSA Communicable disease outbreak management: operational guidance.

11. Norovirus

The winter season of 2024/25 saw cases and outbreaks of Norovirus.

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

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

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

12. Influenza and Respiratory Syncytial Virus (RSV)

During 2024/25 winter season there were cases of Influenza and RSV patients that required timely placement and management. The Specialist Infection Prevention Nurses supported those areas most affected by cases by assisting with the review and management of the side room capacity to support patient placement.

Respiratory testing arrangements were put in place during the Winter 2023 to ensure that patients across the main sites were supported with rapid testing to facilitate timely identification and isolation of infectious cases. The ability to isolate into side room continues to present as a challenge due to lack of side room facilities over the winter period.

12.1 Measles

Measles is a viral infection that causes a variety of symptoms, with more serious complications that occur, especially in children less than 5 years of age, adults older than 20 years, pregnant women, and people with compromised immune systems.

Measles is highly contagious. It is spread by contaminated airborne aerosols and droplets, infecting up to 90% of non-immune individuals in the same room. Contaminated air remains infectious for up to two hours after the patient has left the room.

Before 1970, virtually all UK children contracted measles. An effective vaccine was introduced into the UK immunisation schedule in 1968 and this was responsible for the gradual decline in cases and temporary elimination of measles in 2016 and 2017. However, at least 95% of the population needs to be immune in order to prevent transmission and incomplete coverage, exacerbated by the measles vaccine autism scare in the late 1990s, means that measles re-emerged as a National public health concern during the year 2023/24 and this has continued during 2024/25

The IPT continue to support the implementation of a pathway across LLR that focusses on early identification, isolation, contact tracing to be able to offer timely post exposure prophylaxis and or treatment, communication including public facing messages, staff personal protective equipment and vaccine availability.

UHL Measles 24-25	**Q1**	**Q2**	**Q3**	**Q4**	Totals
Confirmed	30	2	1	2	**35**
Suspected	34	9	10	1	**54**
Contact	111	13	4	15	**143**

Table 9: *shows the number of confirmed, suspected and contact Measles cases 2024/25*

12.2 Tuberculosis

Across LLR there has been a significant increase in confirmed cases of Tuberculosis

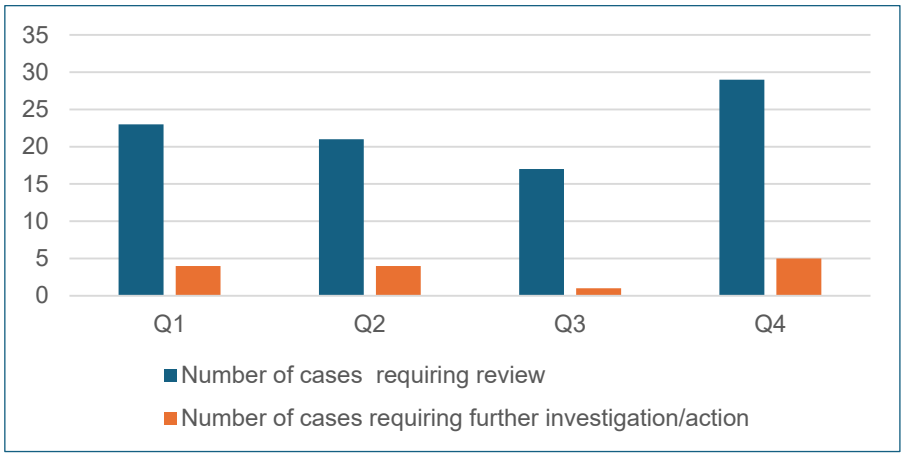


Table 10: *Shows the number of pulmonary TB cases Requiring review by IPT 2024-25*

Q4 was a busy time for TB with our highest number of individual reviews (29) and cases (5) requiring further action

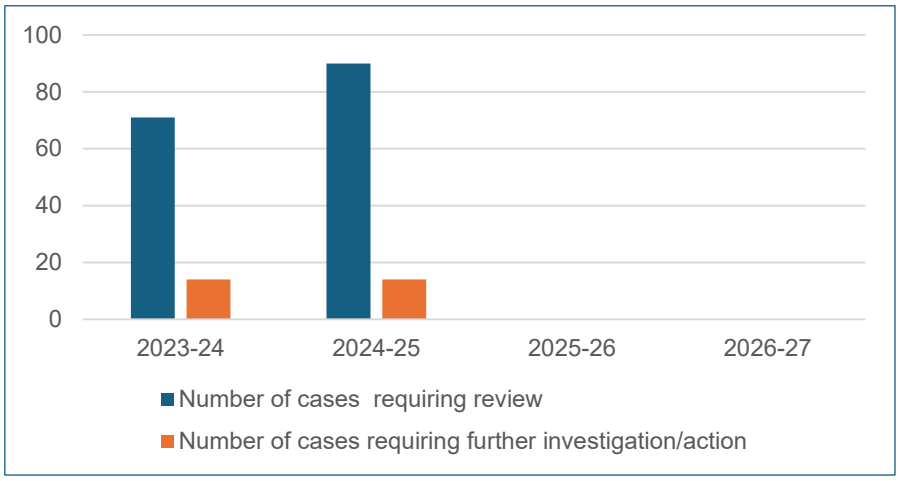


Table 11: *Shows the number of Pulmonary TB cases Review by IPT per Year*

Leicester City has an annual TB rate of 40.3 per 100,000 in 2021 (current data) and is the highest incident of TB in the UK. The work involved with contact tracing patients and staff is growing rapidly

There are a growing number of patients whose first diagnosis is as an in-patient and this has created a growing amount of work for the IPT and TB service. This has reached a point where the impact of this and the resources required have to be reviewed. This is exacerbated by the inadequate number of single rooms within UHL, the proximity of beds within bays and the lack of adequate ward mechanical ventilation.

UHL has a robust process for the management of TB cases once identified and there will be a focus on the response to this infection and the systems and processes in place for the further management of this during 2025/26

12.3 Risk Register and Datix Themes 2024/25

The Datix system is web-based software used primarily in healthcare settings, particularly within the NHS, for incident reporting and risk management. It allows staff to report incidents, near misses, and other safety concerns, which are then logged and analysed to identify potential risks and improve patient safety.

There is one Infection Prevention risk cited on the Trust Risk Register and this relates to bed spacing and is kept under regular review

The slide below indicates the themes that have been identified from a review of the UHL Datix submissions.

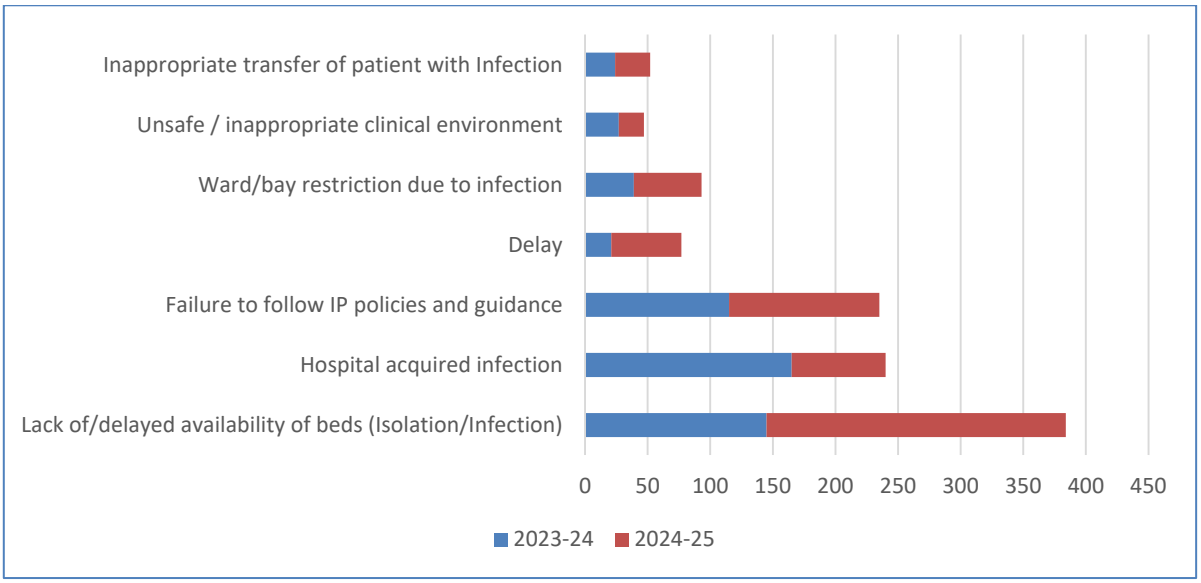


Table 12: *Shows the number and themes of IP Datix by year*

Actions required from the review will be incorporated into the IP programme for 2025/26 to seek to improvement with some of these issues.

12.4 Infection Prevention in the Built Environment

Infection Prevention provides on-going support and advice around all aspects of Infection Prevention in the built environment with a full time senior Infection Prevention nurse embedded within estates and facilities.

There are a number of elements of Infection Prevention in the built environment. These are

- New builds and refurbishments
- Water
- Ventilation
- Cleaning
- Food safety
- Linen
- Waste and sustainability

12.5 New builds and refurbishments

There have been a number of new builds and refurbishments during the past year that Infection Prevention have been involved with, providing advice and support to ensure compliance with regulations such as health building notes and health technical memoranda as well as support during commissioning and opening processes.

These schemes include Leicester south dialysis unit, Peterborough dialysis unit, East Midlands Planned care centre, Hinckley community diagnostic centre, Osborne CRO works, Preston Lodge, Urgent treatment centre planning as well as some other smaller refurbishment projects.

12.6 Food Safety

The Infection Prevention team work closely with the estates and facilities team to ensure that food that is consumed by patients is safe. The food hygiene forward and department kitchens has recently been updated and additional information and advice on the types of foods that are safe for patients to bring in provided.

Formal inspection is carried out by the Local authority environmental health officer but on going inspection of ward and department kitchens occurs throughout the year to ensure standards are being met.

12.7 New Contracts supported by Infection Prevention

In addition to day to day support there have been a number of contracts have been secured that required Infection Prevention input. These include standardising the curtain for bedded areas across the Trust as well as the bed and equipment contract that provides and maintains beds, trollies, couches and patient bed side chairs across the Trust.

Duty of care visits have been conducted to suppliers this year and Infection Prevention have been part of the team carrying out these visits. These ensure that suppliers maintain hygiene standards and store products that are to be consumed in the Trust appropriately.

12.8 Waste and sustainability

Work continues to support wards and departments with compliance with the waste policy with sustainability, continuing to provide behavioural change support through education and audit.

Contracts for the different waste streams have been reviewed and are in place to ensure that there is appropriate segregation of the different types of waste. This ensures that the different streams are taken for appropriate reprocessing.

Linen

Linen such as sheets, pillow cases, blankets and nightwear are provided via a third party provider Elis who both provide the linen and launder the products. Infection Prevention are members of the linen contract review team and have participated in site visits to the laundry to carry out a duty of care visit in order to ensure standards are being met.

12.9 Bed and Mattress Contract

Senior Infection Prevention input has been provided to the Bed and Mattress third party contract review process and this has resulted in the award of a new contract for UHL during 204/25.

IP input is extremely important in this process as the surfaces and integrity of the beds, chairs and equipment on which we place patients is known to be a source of acquisition of micro-organisms and subsequent infection for patients. Ensuring these surfaces are intact and fit for purpose is a vital element of Infection Prevention.

13. Policies Procedures and Guidelines

UHL recognises the importance for staff to have ready access to a full range of Infection Prevention and control policies, procedures and guidelines. Through 2024/25 we have continued to revise Trust policies and guidelines and have included Infection Prevention Pathways to help staff quickly and safely manage patients with infections.

14. Infection Prevention Clinical Audit Programme

The IP audit programme is compliant with The Health and Social Care Act: Code of Practice on the prevention and control of infections and related guidance (2022). The audits include evidence based interventions to reduce the risk of infection to provide education and feedback to clinical staff.

The audit programme is part of the Annual Infection Prevention programme the results are presented to the CMG through the Infection Prevention Dashboard. The dashboard and Action Trackers are reviewed as part of the CMG IP groups and discussed at the TIPOG with escalations and exceptions raised at the TIPAC accordingly.

15. Sharps Audit

An audit of sharps containers is conducted by Mauser TA/Daniels Healthcare, the provider of our sharps bins. Formal audits were undertaken during the year 2024/25 and the results were shared with the CMGs, for any remedial actions..

16. Decontamination

Endoscopy decontamination is conducted within a purpose-built facility, this opened in January 2023. These are operated to HTM 01-06 standards and all staffed are trained to this level. Clinical areas are responsible for the bed side clean (in line with the Endoscopy policy) and the dedicated specially trained decontamination staff are responsible for the pre clean (manual wash)and using the automated decontamination machines. This facility also low stem sterilises all cystoscopes and associated accessories. All staff have specific Decontamination training in Isopharm and are assessed for competence every six months.

The team are currently working through a Quality Management system to be able to apply for ISO 13485 accreditation

Sterilisation of surgical instruments is conducted by our third-party partners (Steris) and a yearly external audit ensures they are compliant to HTM 01-01. As part of the yearly audit the decontamination lead attends the unit and conducts an inspection to give the trust assurance of the external findings. There is also a monthly Joint Business Meeting

where new equipment is discussed and any non-compliances are discussed and documented. This has both clinical and managerial representation for UHL.

The cleaning and decontamination audit described within the Infection Prevention UHL policy (B5/2006) includes guidelines for all staff in the correct cleaning of medical devices .The decontamination lead has now included the questions from the yearly audit within the Board assurance framework , this is reported by the Heads of Nursing at the Trust Infection Prevention Assurance board works closely with the procurement team to ensure compliance to the cleaning products listed within the policy for the use on medical equipment.

The trust decontamination lead sits on the Medical Equipment Executive and can give assurance that any medical equipment brought into the trust has been through an assurance process to ensure the equipment can be decontamination appropriately and all staff are aware of the correct decontamination requirement. When the item is subsequently delivered to the organisation the staff are aware of the requirements.

17. Estates and Facilities Management

17.1 Water

Water provided for drinking and bathing naturally contains small amounts of bacteria, including Legionella species and Pseudomonas aeruginosa that can cause infection if allowed to build up into large numbers. This is a particular concern in hospitals because of the vulnerability of patients. Consequently, the Trust has established strategic and operational arrangements aimed at minimising infection risk from water. Both strategic and operational water groups remained in place and meet regularly

The Water Safety Group (WSG) chaired by the Consultant Microbiologist with representation from Estate, Capital, IP, CMG and the Authorising Engineer convenes quarterly and reports to TIPAC

The Operational Water Task Group convene monthly with multidisciplinary members including contractors to progress issues as they arise and report upwards to the WSG.

The incumbent Authorising Engineer (AE) Water contract has been extended to support the Trust in monitoring compliance in line with HTM, including the biannual compliance audits. Additional services have also been procured via the AE service to provide a more proactive and technical approach in supporting the Trust's water management agenda.

The Water Management UHL Policy (A1/2004) reviewed April 2024 with a planned review due 2027. The supporting Water Safety Plans due for review in Q2 2025.

The revised and extended water sampling programme across the Trust has run to schedule with all adverse results reviewed and actioned on a fortnightly basis by Estates, Compliance and Infection Prevention colleagues. The output from the enhanced management and flushing protocols has been a significant reduction in overall positive samples for Legionella and Pseudomonas across the Trust and a declining trend in Long Term Positives

Flushing compliance reports continue to be issued to the Heads and Deputy Heads of Nursing to review and onward cascade to CMG level on a monthly basis.

Duty of Care (DOC) audits continue for community locations, including Renal Services, and provide assurance around water management provided by third parties.

18 Vascular Access Committee

A Vascular Access Committee within UHL previously reported to the Trust Infection Prevention Committee on any matters that related to Infection Prevention within medical devices that enter the sterile circulatory system. It was agreed with the Medical Director that the governance of this should be managed via a Quality and Safety Committee, this commenced during 2024/25. The Chair of this Committee is now the Deputy Medical Director.

A review of the terms of reference and clinical representation for this group, workplans and priorities to ensure it is fit for purpose continues. An application for a Transformation Team dedicated review of the service across UHL has been made and a response is awaited.

19 Occupational Health

Our Occupational Health (OH) service remains an integral part of our organisation and continues to play an important role in supporting our staff and their managers with all matters relating to health and work. We protect the health of the workforce through vaccination against common infectious diseases, as well as those which may be specifically encountered in UHL as a workplace. This encompasses a wide variety of staff groups, from laboratory workers handling specific infectious agents, clinical staff who may be exposed to measles, Pertussis , chickenpox and tuberculosis for example, and staff in all areas of the hospital who may be exposed to influenza. The most well-known occupational vaccination programme continues to be for Hepatitis B and demonstrating non-infectivity for Hepatitis B is mandatory for some occupational groups. We also undertake screening for other blood borne virus infections in clinical staff who undertake specific procedures e.g. surgery, midwifery.

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

The challenges for the service in the past year have centred around a rise in cases of measles, pertussis and TB. We have continued to support the process for risk assessment of staff with vulnerabilities in relation to measles, as well as the vaccination campaign for both measles and Pertussis and have continued to collaborate with colleagues in the Infection Prevention and Control Team to assist with management of outbreaks and exposures in clinical areas. The OH service has supported the approach to staff immunity testing for measles and isolation where required, as well as providing strategic advice in the organisation for measles and pertussis.

The Occupational Health service again retained its independent accreditation as a Safe, Effective, Quality Occupational Health Service (SEQOHS) following annual review in November 2024, and remains a centre for training in Occupational Medicine, being one of only three units in the UK able to support three medical trainees.

As we look forward to the next year, we continue our work to bring greater alignment of the OH service with the counselling service (Amica) and the Wellbeing initiatives in the organisation, and in so doing improve the user interface of our service for our staff.

20 Next Steps

We will continue to strengthen the work streams identified during 2024/25 for 2025/26

We continue to refine the Infection Prevention reviews using the Patient Safety Incident Response Framework NHS England » Patient Safety Incident Response Framework and system based approaches.

In turn this above approach will help to further develop our HCAI and Gram Negative Bacteraemia Reduction Programme key elements of this being

- A Catheter Associated Urinary Tract Infection reduction programme
- Support vessel health and reduce bacteraemia through membership of the Vascular Access Committee. A Transformation Whole Service Review has been requested for 2025/26
- Support the development of the 'Mouth care matters' initiative of which one objective is reduction of fungal mouth infections
- Continued support of The Nutrition and Hydration steering group where adequate hydration of patients supports reduction of urinary tract infections
- Actions from the Datix system review will be taken forward during 2025/26

To further develop the digital platform that underpins the UHL IP BAF.

To explore multi model methods of delivery to support the ongoing training and education programme to ensure we remain current and up to date with learning requirements

Support the establishment of the Antimicrobial Stewardship Programme delivered through a revised committee within the Trust

To further develop IP data collection systems within Nerve Centre

To support UHL to develop the Surgical Site Infection Surveillance on all the recommended areas by UKHSA of surgery and provide Trust wide bundles of care based on the findings and recommendations of this.

To support the enhancement of the ICCQIP quality improvement programme across our Critical Care Units

To strengthen our response to any query or identified High Consequence Infectious Disease across UHL

To fully support the embedding of the National Standards for Cleanliness Programme across the Trust

Horizon scan for future improvements or innovations across the Infection Prevention pathway

Have an ambition to host a Midlands Region Surgical Site Infection Surveillance Conference and Infection Prevention Conference 2025/26

Meeting title:	Quality Committee	**Paper N**
Date of the meeting:	28th August 2025	
Title:	Dementia Services and Enhanced Care Annual Report	
Report presented by:	Julie Hogg, Chief Nurse	
Report written by:	Wendy Clarke, Lead Nurse Charlotte Leeds, Matron	

Action – this paper is for:	Decision/Approval		Assurance		Update	x

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
N/A

Impact assessment
Patients • Improves the quality of care for patients and their carers through therapeutic interventions. • Enhances the pathway of care, ensuring better outcomes and experiences. **Equality, Diversity & Inclusion** • Supports personalised care tailored to individual needs. • Promotes inclusive practices across dementia and delirium services. **Reputation / Legal** • Strengthens the organisation's reputation by delivering outstanding care. • Demonstrates commitment to legal and ethical standards in patient care.

Acronym	Definition
D&DSAG	Dementia and Delirium Strategy Action Group
EPO	Enhanced Patient Observation
GGH	Glenfield General Hospital
GIRFT	Getting It Right First Time
LGH	Leicester General Hospital
LLR	Leicester, Leicestershire, and Rutland
LRI	Leicester Royal Infirmary
MDT	Multidisciplinary Team
OPDC	Older People and Dementia Champions
UHL	University Hospitals of Leicester

Purpose of the Report

The purpose of this report is to update and provide assurance to the Quality Committee on the progress and impact of our Dementia Services and Enhanced Care in 2024-25. As a service we are committed to providing high quality person-centered care to individuals living with dementia, and this report highlights the outcomes of our efforts in line with our strategic goals.

Recommendations

The committee is asked to:

- Note the update of the Dementia and Delirium services provided across University Hospitals of Leicester (UHL).
- Be assured by the progress to date and priorities for the coming year.

Summary

This annual report outlines the key achievements, challenges and future actions of the dementia services for the year 2023/24. The report focuses on four core areas:

- Meaningful Activities Service
- Admiral Nurse service
- Enhanced Patient Observation team
- Actions taken by the Dementia and Delirium Strategy Action Group.

The dementia services have made significant strides in improving the quality of life for our patients living with dementia, providing critical support to families, and contributing towards UHLs quality and medical dementia strategy.

Main Report Detail

Meaningful Activities Service

1.1 Overview

The Meaningful Activities Service was established in 2013. The service currently consists of 12.4WTE Meaningful Activities Facilitators (MAFs) and was launched to support and enhance the hospital stay for people living with dementia (PLWD) and/or delirium in UHL by engaging with patients in a meaningful approach.

1.2 Activities

The service has supported 2677 patients in 2024-25 using a range of interventions to support PLWD or experiencing delirium.

Therapeutic activities include meaningful conversation, reminiscence, music, and arts and crafts. These support the PLWD and/or delirium and the clinical teams to promote oral intake, mobilisation, personalised care and communication with family. They work alongside the MDT using activity and reassurance to support procedures to be completed without using physical or chemical restraint.

Person-centred care is fundamental in dementia care, and the MAFs plan their interventions through completing the Know Me Better Patient Summary. This enables them to personalise their care and provide appropriate support. The interventions do overlap. For example, the team use creative expressive interventions (music/dance/arts and crafts) to encourage nutrition and hydration, and the

Reminiscence Interactive Therapy Activities (RITA) to promote independence and maintain identity.

Examples of activities completed with patients by the MAF service.

Reasons for Referral (2024–25)

A total of **2,677 patients** were supported through various interventions. The five most frequent reasons for referral were:

Reason for Referral	Percentage
Support general wellbeing	32%
Support nutrition and hydration	17%
Patient displaying altered behaviour	15%
Support MDT interventions (e.g., assessments/treatments)	14%
Low mood	13%

The majority of patients are seen within the Emergency Department and Emergency Floor at LRI. At the end of Q4, targeted improvement work was initiated to increase the number of patients with dementia and/or delirium supported by Meaningful Activities Facilitators (MAFs). The primary aim is to reduce the likelihood of delirium onset in this patient group, recognising its significant impact on patient outcomes.

The majority of the service is based at LRI, with an increasing number of patients seen at LGH due to the Specialist Medicine wards there during 2024-25.

1.3 Service Improvements

In Q4 the service moved from paper-based to online data collection with support from the Clinical Audit Team. This has positively impacted on both services. Paper forms required a strict completion and filing process, and required laborious scanning and inputting by the Clinical Audit team. Data inputting time has been reduced for both teams. The paper forms were limited in length, whereas online data collection allows for the more specific and better quality data to be collected. This was trialled in Q4, and will be further expanded in 2025-26 to include patient outcomes.

1.4 Challenges and Solutions

Resource limitations: The primary challenge has been the availability of staff to meet the demands of the service. The data suggests an increase in the demand for assistance at the LGH site and across many other CMGs.

To address these challenges and maintain the high standards of care that Dementia Services currently provide, we propose to expand using a similar model to the Emergency Department for the potential transfer of funds to provide a standardised service to maximise the efficiency of rotas and training and development opportunities.

2. Admiral Nurse Service

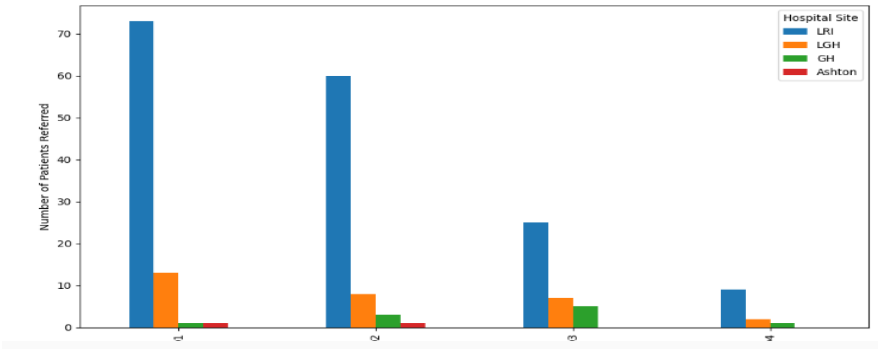
2.1 Service Overview

Admiral nurses support the most vulnerable people living with dementia and their families, who often have complex health and social care needs. Such patients are identified as requiring 'Complex support', known as 'Tier 3'. Any unmet needs are identified, and associated 'intensity level' is determined, giving an overview of the level of complexity of each patient. See Appendix 1 for a full overview of Admiral Nursing.

UHL Admiral Nursing Service, in partnership with Dementia UK, has been running for six years. The service has consisted of 1.8 WTE clinically facing specialist nurses who support best practice, person-centred and relationship-centred care, holistic assessment, staff training and development, admission avoidance, early discharge and advance care planning.

Due to vacancies in both Admiral Nurse posts, the service experienced a temporary reduction in capacity during Q3 and a complete pause for six weeks in Q4. This contributed to a 37% decrease in overall referrals. In response, the service was restructured, resulting in the appointment of a 1.0 WTE Dementia Services Department Leader (Band 7 Nurse) in Q4, ensuring continued leadership and support.

Quarterly Patient Referrals by Hospital Site (2024/5)



2.2 Performance Metrics

Most patients and families were referred to the service to support Carer strain/fatigue with or without a change in presentation. Table 2 outlines the primary reason for referrals.

Table 2. Primary Reasons for Referrals 2024-25

Reason for referral	Number (%)
Carer Stress/ Fatigue + Change in presentation	32%
Carer Stress/ Fatigue	29%
Clinical Advice and management	11%
Change in presentation	8%
Carer Stress/ Fatigue + Transition of care	4%
Frequency of Admissions	4%
Carer Stress/ Fatigue + Sharing Best Practice in Dementia Care	4%
Sharing Best Practice in Dementia Care	4%
Sharing Best Practice in Dementia Care + Transition Of Care	2%
Sharing Best Practice in Dementia Care + Change in Presentation	1%
Transition of Care + Change in Presentation	1%
Transition of Care	1%
Total	**209**

2.3 Contacts with Patients, Families/Carers and Staff

Each referral may result in multiple contacts with patients and their relatives/carers, lasting for varying times depending on the type of intervention required. Contacts may in addition be after the patient has been discharged. A list of types of contacts is in Appendix 1.

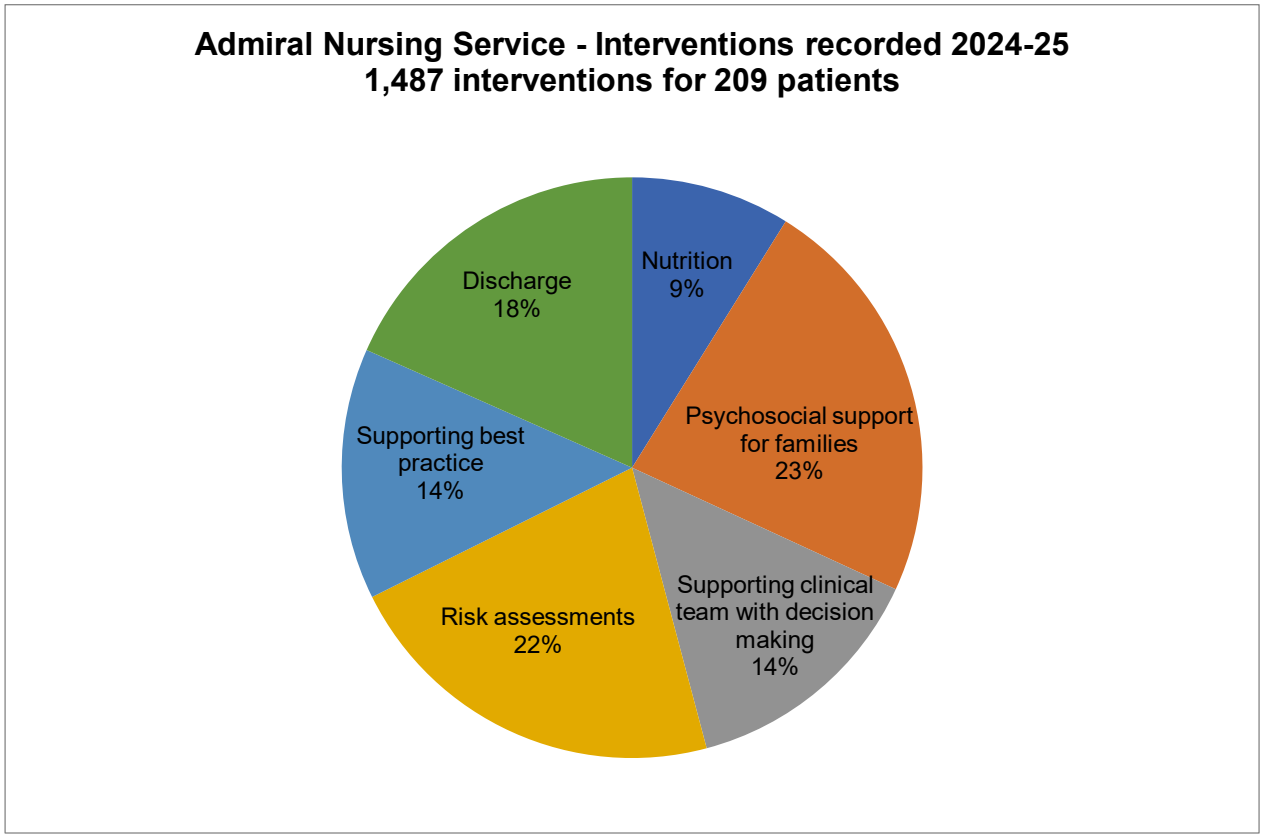
The total number of contacts in 2024-25 was 820, which has decreased by 8% compared to 2023-24, due to the temporary gap in vacancy. See Table 3.

Table 3. Contacts with Patients 2024-25

Quarters 2024-25	All Inpatient Contacts	All Outpatient Contacts	Crisis Calls	Staff Support	Total Contacts
Q1	213	104	6	3	326
Q2	184	96	9	3	292
Q3	117	42	2	5	166
Q4	17	13	2	4	36
Total (%)	**531 (65)**	**255 (31)**	**19 (2)**	**15 (2)**	**820**

Similar to the MAFs, multiple interventions may be undertaken with each patient and their relative/carer. These are categorised, and summarised in Figure 1. A full breakdown of interventions is in Appendix 1.

Figure 1. Types and % of Interventions with Patients and Families/Carers



2.4 Long-Term Patients Clinic

In January 2022, a Long-Term Patients Telephone Clinic was set up to support patients that have been discharged from UHL due to lack of Admiral Nurse Provision within community services across LLR. The clinic provides ongoing support to those patients and their families/carers. Nine patients were supported in the clinic in 2024-25. Criteria for inclusion in the clinic are:

- Complex needs of persons living with dementia and lack of support services in the community to meet those needs
- Significant spousal carer strain due to complex needs of PLWD
- Transition of care to care home
- Bereavement Support

2.5 Feedback

The Admiral Nurses have continued to collect feedback from families they have supported, through sending an email link or postal surveys to families and carers. 100% of respondents reported that the service they received was ‘good’ or ‘very good after engaging with the Admiral Nurse Service.

Below is a selection of comments taken from the free text on the completed surveys from family members or carers:

“Very helpful and supportive to the whole family as well as the patient. So friendly and significantly care”

“Absolutely wonderful I don’t know what I would have done without the support and advice they have given to me. I cannot express enough the care shown especially to my mum. I don’t know what I would have done without the most wonderful nurses. I will be forever grateful. Thank you.”

“Just highly helpful and caring, and always called back and called ME.”

“This team is absolutely crucial for families like us who have a loved one with Dementia as it requires a specialist team who fully understands this devastating illness. Without the admiral nurses we would’ve had nowhere to turn. They are brilliant.”

2.6 Collaborations and Training

To promote multi-professional learning from cases, the Admiral Nurses have continued to lead a weekly Dementia MDT to discuss and share complex patients with the Clinical Lead for Dementia, the Mental Health Liaison Service, and the Specialist Medicine discharge team.

During Dementia Action Week 2024, the Admiral Nurses and Meaningful Activities Service promoted the Older People and Dementia Champions network, training over 50 new champions. Quarterly link sessions for existing champions have taken place and been fully attended.

The Dementia Awareness Category A and B Training are essential to role (Dementia B for patient-facing staff only), has been reviewed with the support of the Education and Practice Development Lead and is in line with the Dementia training standard framework. Dementia training has continued to be delivered online via Teams, increasing the capacity to 100 enabling more staff to join the session. The Education and Practice Development team deliver the training to new Healthcare Support Workers during their induction. To date 98% of members of staff are compliant with Dementia A training, and 89% Category B. To achieve the target of 95% of staff completing the Dementia B training, the training compliance will form part of the D&DSAG agenda.

The service has continued to support the Enhanced Patient Observation induction training, and hosted educational stands at all three hospitals, and UHL Leadership Conferences.

2.7 Service Highlights

The Admiral Nurses have continued to support new members of the MDT with regular requests for staff members to shadow them in their clinical work. In addition to sharing best practice, the Admiral Nurses have continued to develop professional knowledge and skills through attending Dementia UK Admiral Nurse training sessions including the Admiral Nurse forum. During the year the Admiral Nurse Steering group has continued six-monthly in conjunction with Dementia UK.

3.0 Enhanced Patient Observation Service

In November 2023, UHL launched the Enhanced Patient Observation (EPO) Service following a comprehensive review of one-to-one (1:1) care. Formerly known as specialing, EPO—also referred to as Enhanced Therapeutic Observation and Care (ETOC)—is vital for the safe and effective management of patients in acute hospital settings who are at risk of harm to themselves or others.

The EPO model was introduced in response to a significant rise in demand for enhanced therapeutic care, previously met through temporary staffing, including agency and security personnel. Initially, the provision lacked formal governance, highlighting the urgent need for robust oversight and consistent standards to ensure safe, effective, and appropriate use of additional staffing.

EPO is typically required when patients exhibit challenging behaviours due to cognitive impairment, acute illness, or mental health conditions. These behaviours may be temporary (e.g., delirium, substance withdrawal) or permanent (e.g., dementia), and often occur in patients subject to legal frameworks such as the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS).

3.1 EPO Service at UHL

The service has expanded gradually throughout 2024–25, with key considerations including:

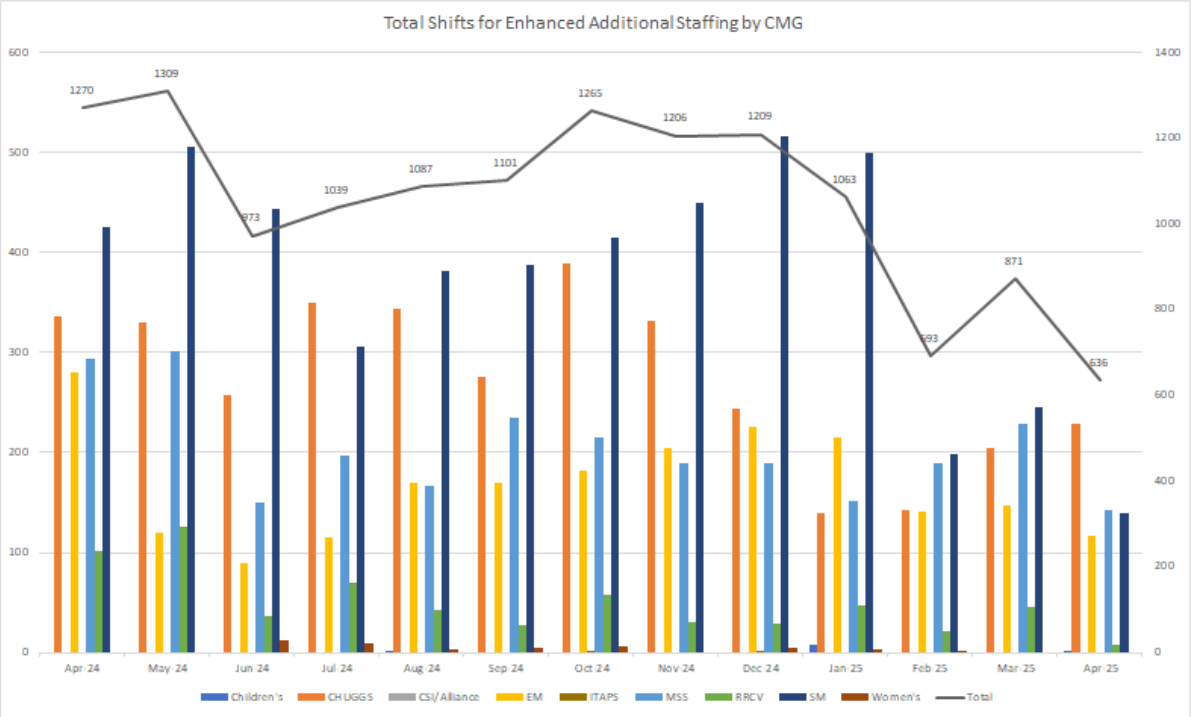
- Recruitment of Healthcare Support Workers (HCSWs)
- Comprehensive training programmes, including a supernumerary period
- Collaborative engagement with wards before and after integration, ensuring staff understand the purpose, remit, roles, and responsibilities of the EPO service

Currently, all supported wards are located at the LRI and the Lead Nurse supports remotely for advice on the other sites.

The EPO service currently consists of 38 WTE HCSWs covering a 24/7 roster and 4 WTE Registered Nurses (RNs) (a Department Leader and three Deputy Department Leaders) available 08.30-20.00 daily.

Looking ahead to 2025/26, the service aims to expand throughout the remaining adult wards and the LGH and GGH sites, ensuring equitable access to enhanced care across the trust.

The table below presents data from 2024/25 on additional duties requested across UHL. As the service has expanded, the number of enhanced care allocations has decreased, suggesting more appropriate and targeted deployment of resources.



3.2 Metrics

The EPO service has developed monthly metrics to obtain quantitative data; these were rolled out in October 2024. Assurance of the standard of care is monitored against the following key performance areas:

- Delirium - Ensuring HCSWs are aware of a diagnosis and deliver care aligned with NICE guidelines
- Preservation of dignity and personalised care – Ensuring dignity is maintained and care is tailored to the patient (e.g. bespoke therapeutic activities)
- Preventing deconditioning – Encouraging physical activity and movement to maintain function
- Monitoring of nutrition – Ensuring accurate nutritional support to facilitate recovery.

This structured approach highlights areas for improvement, and supports the delivery of high-quality, person-centred care.

Notably, delirium-related metrics improved from 60% to over 80%, reflecting increased staff awareness and understanding. To further support this, resource boxes containing tools such as orientation calendars have been deployed across all wards supported by EPO.

All other key performance areas have consistently exceeded 80% compliance. In addition, clinical supervision has been introduced by EPO assessment nurses to reinforce learning, support development, and embed best practice across the team.

3.3 Training and Education

The EPO service has demonstrated notable cost savings (including through reduced use of temporary staffing), and reduction in safeguarding referrals and contributed to reduced harms through its patient-centred holistic approach. A variety of clinical areas have benefitted from training provided by the EPO assessment nurses, Matron, and Lead Nurses including:

- Professional Nurse Forums
- Ward-specific training sessions/days, such as Band 6 nurse training, team meetings, time-out days
- Safer Staffing training days
- Nurse in Charge training days
- Older People and Dementia Champions

The lead Nurse has contributed to the regional and national ETOC Network, notably on the quality of processes in place at UHL and a specialist training programme.

The service has supported shadowing opportunities from within and outside of UHL to improve the identification of unmet needs that may contribute to agitated behaviours and behaviours that challenge.

In practice the EPO HCSWs work closely alongside the Meaningful Activities Facilitators, who in addition specialise in providing holistic patient activities for patients with dementia and/or delirium.

3.4 Feedback

As a newly established service, understanding its impact on patients and carers has been a key priority. In October 2024, a feedback mechanism was introduced, enabling patients and/or their relatives and carers to anonymously share their experiences.

Below are selected examples of the feedback received:

"Very impressed with how [EPO HCSW] is looking after my Father. His attention to detail & his caring & empathy & interaction is exceptional."

"I was able to go home at night knowing my mother was in safe hands with 1:1 care and I would be immediately notified if I was needed"

"Humbled by the compasion, profesionalism and pure skill set that [EPO HCSW] shown with his ability to adapt his conversation to either pick up the mood or calm down any situation"

4.0 Dementia and Delirium Strategy Action Group

4.1 Overview

The Dementia Strategy Group was originally formed to develop and implement strategies aimed at improving dementia care across our organisation was temporarily disbanded due to covid-19 due to resource constraints. It was re-established in January, 2024. The reformed group now named the Dementia and Delirium Strategy Action Group, expanding its remit to include delirium alongside dementia. Led by the Associate Medical Director, and Deputy Chief Nurse the group focuses on enhancing best practices, improving patient outcomes, and ensuring comprehensive care for all patients with cognitive impairments.

4.2 National Audit of Dementia

Between August 2023 – January 2024 the trust participated in the sixth round of the Royal College of Psychiatrists National Audit of Dementia Care. The audit was open to all general acute hospitals in England and Wales providing acute services on more than one ward which admits adults over the age of 65. In England and Wales, 177 hospitals (93% of eligible hospitals) took part in this round.

Despite Leicester Royal Infirmary appearing strong performance in key areas such as delirium screening and pain reassessment, we are aware we are not using the recommended formal assessment tools. Challenges remain in discharge planning and carer satisfaction. By addressing these gaps through targeted interventions, the hospital can further enhance the quality of dementia care and align its practices with national standards. Implementing these recommendations will support continuous improvement, ensuring better outcomes for patients and their carers.

4.3 Key Actions:

Improve Delirium Screening Tools Usage:

- Conduct training sessions on structured tools available on NerveCentre to ensure consistent application.

- Monitor compliance with the delirium screening tool through monthly data collection to the quality committee.

Promote Structured Pain Assessments:

- Increase the use of the validated Cannot Verbally Express (CVE) Pain tool which is available on NerveCentre.

- Monitor the use of the CVE tool on NerveCentre.

Enhance Discharge Planning:

- Develop a standardised process to initiate discharge planning within 24 hours.

- Address common barriers by implementing multidisciplinary rounds to discuss patient needs early.

- Consider improvements in patient pathways for patients living with dementia such as use of community hospitals and virtual wards.

Strengthen Carer Communication:

- Establish regular updates for carers during the hospital stay to keep them informed about care plans.

- Involve carers more actively in decision-making processes and provide resources to support them in their roles.

4.4 NerveCentre

Significant improvements have been made within NerveCentre to better support patients with a diagnosis of dementia and/or delirium:

- **Alert System Update:** The default "Violent and Aggressive" tag has been amended to read:
  "Violent and Aggressive – Not Dementia/Delirium"
  This change helps prevent inappropriate labelling and promotes a more compassionate understanding of behaviour linked to cognitive impairment.

- **Referral Integration:** Referrals to the Meaningful Activities Service are now processed directly through NerveCentre. This has led to a marked increase in patient engagement and timely support.

- **Live Flow Page:** A dedicated live flow page has been developed to track patients with a dementia diagnosis across UHL. This has significantly improved visibility for the Admiral Nurse and Meaningful Activities teams, enabling more responsive and coordinated care.

- **Service Profile Pages:** All Dementia Services now have individual profile pages within NerveCentre, enhancing communication, efficiency, and service integration across the Trust.

Supporting Information

Appendix 1

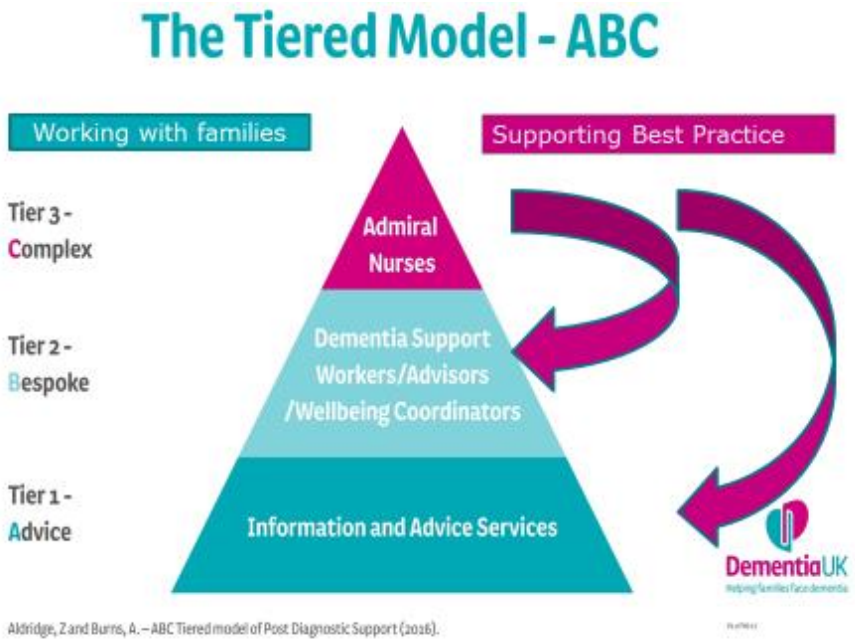
Overview of Admiral Nurse Service at UHL

Overview of Admiral Nurse Service at UHL

Referral Criteria

Admiral Nurses aim to enhance the care and experience for people living with dementia (PLWD) and families when admitted to the Trust, delivering person- and relationship-centred dementia care for patients and families/carers. They support the most vulnerable people living with dementia and their families, who often have complex health and social care needs. Such patients are identified as requiring Tier 3 Complex support, as highlighted in Figure 1.

Figure 1. Dementia UK Tiered Model



For PLWD, admission to the hospital can create additional challenges, risks and anxieties not just for them but also for their families. This is due to the hospital being an unfamiliar environment: the noise, the busy pace and the general routine disruption can be frightening and disorientating. The Admiral Nurse Service advocates for patients and their families/carers through their specialist role, including the promotion of initiatives already available within the Trust, such as John's Campaign (known as 'Stay With Me') and the Dementia Friendly Hospital Charter.

University Hospitals of Leicester (UHL) is one of only 34 acute Trusts offering support to PLWD through an Acute Admiral Nursing Service. The service has played a pivotal role in maintaining communication between the wider healthcare team and the families of PLWD; the excellent feedback they receive from families reflects how important this has been to them over the years.

The service is an integral part of the Multidisciplinary Team (MDT), valued by Consultant Geriatricians, staff on Older Peoples wards, Mental Health Liaison Service, and local Admiral Nurse Services. It is part of the Dementia Services at UHL, working alongside colleagues in the Meaningful Activities Service.

Contacts With Patients, Families/Carers and Staff

Each referral may result in multiple contacts with patients and their relatives/carers, lasting for varying times depending on the type of intervention.

Contact will be:

- When the PLWD is an inpatient, which may require multiple follow-ups during their hospital stay
- By telephone as a 'Discharge Follow-Up' within the first month of discharge from the hospital; this may be one or multiple contacts
- By telephone within the 'Long-Term Patients' clinic for up to a year after discharge from hospital; this may be one of multiple contacts, and is only for those identified as needing ongoing support from an Admiral Nurse.

Additionally, telephone calls may be received as a crisis call from relatives/carers who are either:

- already known to the service, and the PLWD is an outpatient or
- have been previously known to the service or
- are not known to the service but have obtained the contact telephone number through the Dementia UK website.

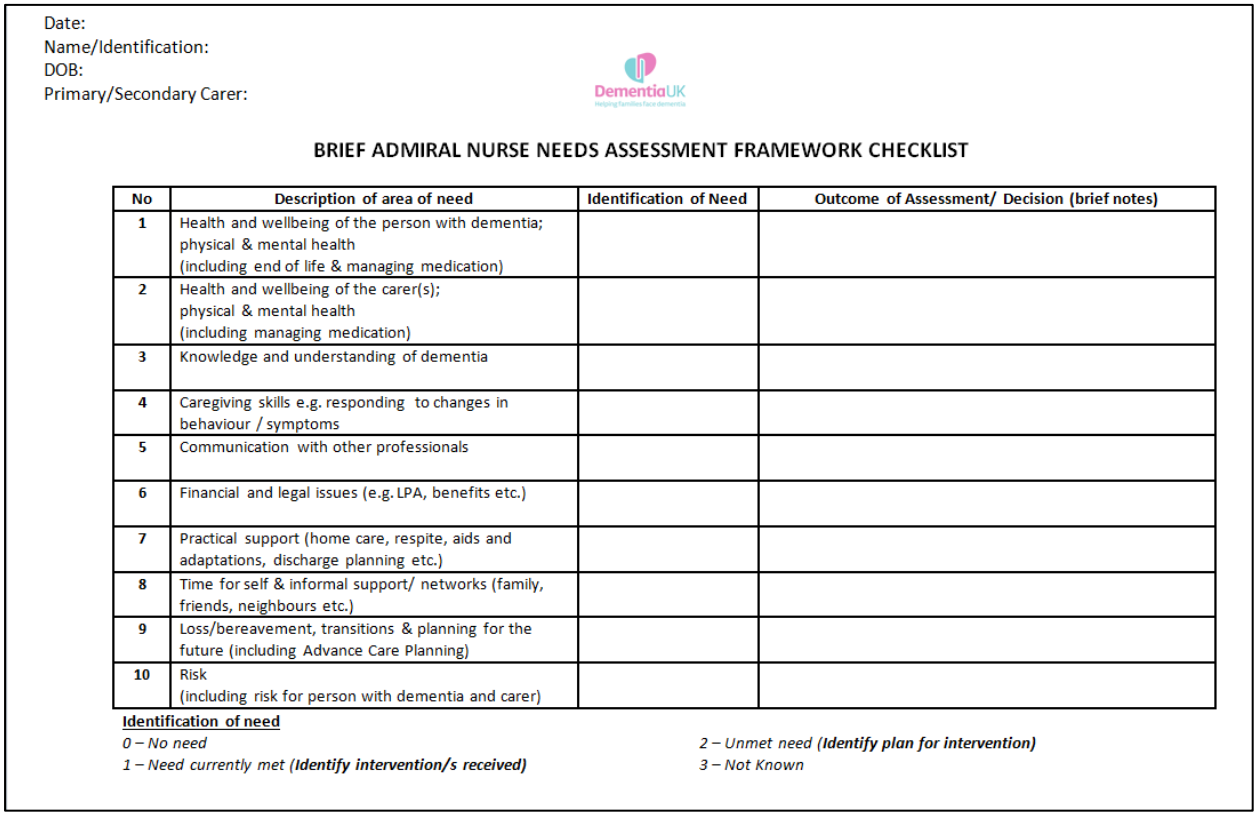
A crisis call is defined as a family member or carer unexpectedly getting in touch for advice and/or support.

Contacts from staff may be for a variety of advice and/or support, ranging from best practice for an inpatient they are caring for, to personal situations involving dementia, such as help to care for their own loved one. These contacts may be by telephone or email.

Needs Assessment Framework

Unmet needs are described and identified using Dementia UK's Brief Admiral Nurse Needs Assessment Framework (Figure 2).

Figure 2. Brief Admiral Nurse Needs Assessment Framework Checklist



Date:
Name/Identification:
DOB:
Primary/Secondary Carer:

DementiaUK

BRIEF ADMIRAL NURSE NEEDS ASSESSMENT FRAMEWORK CHECKLIST

No	Description of area of need	Identification of Need	Outcome of Assessment/ Decision (brief notes)
1	Health and wellbeing of the person with dementia; physical & mental health (including end of life & managing medication)		
2	Health and wellbeing of the carer(s); physical & mental health (including managing medication)		
3	Knowledge and understanding of dementia		
4	Caregiving skills e.g. responding to changes in behaviour / symptoms		
5	Communication with other professionals		
6	Financial and legal issues (e.g. LPA, benefits etc.)		
7	Practical support (home care, respite, aids and adaptations, discharge planning etc.)		
8	Time for self & informal support/ networks (family, friends, neighbours etc.)		
9	Loss/bereavement, transitions & planning for the future (including Advance Care Planning)		
10	Risk (including risk for person with dementia and carer)		

Identification of need

0 – No need
1 – Need currently met ***(Identify intervention/s received)***
2 – Unmet need ***(Identify plan for intervention)***
3 – Not Known

Patient Intensity

The Admiral Nurses also use The Intensity Framework (Table 1) to understand better the complex and varied needs of PLWD and families who require Admiral Nurse input.

The 'Intensity Level' highlights the complexity of the individual and what unmet needs they and their family/carers have, indicating the level of support and input they are likely to require. This concise documentation method reduces time spent assessing patients' and families' needs and support, enabling Admiral Nurses to support patients and plan care effectively.

Table 1. Summary of the Intensity Framework

High *the most intensive level*	Patient/family having *6 or more* unmet needs
Medium	Patient/family having *3-5* unmet needs
Low	Patient/family having *2 or less* unmet needs
Not fully assessed	Patient/family followed up only by phone or referral triaged as inappropriate.

Interventions

The Admiral Nurse Intervention Tool provides clear measures of interventions beneficial to PLWD and their families when admitted to the trust, identified through the specialist skills and assessments made by the Admiral Nurses. The tool enables emerging themes to be identified as well as areas for development, training and

sharing best practice.

NHS
University Hospitals of Leicester
NHS Trust

Admiral Nurse Interventions

Code	Intervention	
1	**Nutrition**	
A	Meal planner	
B	Finger foods	
C	Mouth care	
2	**Psychosocial support for Families**	
A	Education	
B	Emotional support	
C	Practical Advice	
D	Promoting carer charter	
3	**Supporting clinical team with decision making.**	
A	Respect form	
B	Feeding at risk	
C	EHCP/ACP	
D	Best interest decision	
E	Clinical advice and management	
4	**Risk Assessments**	
A	Safeguarding	
B	Falls risk/ mobility	
C	Continence	
D	Pain	
E	Delirium 4AT	
F	Cognition – AMT 10	
5	**Supporting best practice**	
A	Referral on to specialist teams	
B	Promoting FGMN scheme	
C	Support spiritual and religious needs	
D	Patient summary	
E	Supporting teams with EOL care	
6	**Discharge**	
A	Enable carers to continue caring	
B	Involving patients and carers in discharge planning	
C	Capacity and decision making (A/N support and advice)	
D	Supporting Discharge process	