University Hospitals of Northamptonshire NHS Group

University Hospitals of Leicester NHS Trust

UHL/UHN Boards in Common Paper F2

Meeting title:	Boards of Directors of Kettering General Hospital NHS Foundation Trust (KGH), Northampton General Hospital NHS Trust (NGH) (University Hospitals of Northamptonshire NHS Group - UHN) and the University Hospitals of Leicester NHS Trust (UHL) Meeting together (Public)
Date of the meeting:	9 April 2026
Title:	**Escalation Report from the Quality Committee (QC): 26 March 2026**
Report presented by:	Andy Haynes, MBE, QC Non-Executive Director Chair
Report written by:	Andy Haynes, MBE, QC Non-Executive Director Chair

Action – this paper is for:	Decision/Approval	X	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						
BAF Risk 01 Quality 05 – Tackling Health Inequalities						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee (QC).

Summary

Quality Committee met on 26 March 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out the QC's level of assurance.

This escalation report follows the new quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations**; **actions to take outside the Committee**; **positive assurances**, and **decisions taken**.

The Committee recommends approval Patient Safety Incident Response Plan (PSIRP) 2026/28 which is appended .

The escalation report also sets out any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

Unclassified

Quality Committee 26 March 2026 – Non-Executive Director Committee Chair's escalation report

<table>
<tr><th>Key escalations to notify the Board</th><th>Actions to take outside of the committee</th></tr>
<tr><td>BAF Risk 01 Quality 05 – Tackling Health Inequalities
Gap identified in visibility of equity insights

UHL Annual Prevention Report 2024/5
This report will be launched at the third UHL Health Equality Summit in April. It relates the background, position and progress on Smoking Cessation, Alcohol Abuse, Obesity, TB, Blood Borne Viruses and Workforce Wellbeing. Progress has been made but more remains to be done. The report recommends that we use our digital infrastructure to offer pathways to those that need them most, enhance communication across OP services and to primary care whilst continuing to evaluate impact to maximise funding opportunities. QC fully supports and recommends this report. Recent national guidance covers all of these areas and cardiovascular disease (CVD); QC asked how CVD prevention fits into our local strategy and this will come in a future report. The Committee's discussion on this report is highlighted to the Board for information and the report attached for the Board's awareness.

(Strong Assurance)</td><td></td></tr>
<tr><th>Positive Assurance taken</th><th>Decisions taken</th></tr>
<tr><td>Reports reviewed:
Monthly AQIP
Quality and Safety
Q3 Patient Safety
Q3 Safeguarding

(Strong Assurance)</td><td>PSIRP Plan 2026/8 approved</td></tr>
<tr><th colspan="2">Items recommended for Board approval:</th></tr>
<tr><td colspan="2">Patient Safety Incident Response Plan (PSIRP) 2026/28 (appended to this report for approval)</td></tr>
</table>

Items referred to other committees:
None

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

Meeting title:						
Date of the meeting:	9 April 2026					
Title:	Patient Safety Incident Response Plan (PSIRP)					
Report presented by:	Ms Julie Hogg, Group Chief Nurse & Dr Gang Xu, Medical Director					
Report written by:	Ms Claire Rudkin, Head of Patient Safety					
Action – this paper is for:	Decision/Approval	x	Assurance		Update	
Where this report has been discussed previously	UHL Patient Safety Committee 17 March 2026 UHL Quality Committee 27 March 2026					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
BAF Quality Risk 01 (lack of a fully embedded Quality Governance and Assurance framework, may result in failure to maintain and improve patient safety, clinical effectiveness, and patient experience)

Impact assessment

Acronyms used
PSII – Patient Safety Incident Investigation PSIRF – Patient Safety Incident Response Framework PSIRP – Patient Safety Incident Response Plan PSP – Patient Safety Partner

Context

In line with national requirements organisations are required to develop a patient safety incident response plan in line with the national template as part of their PSIRF planning. The plan sits alongside an organisation's patient safety incident response policy to guide responses to patient safety incidents. An organisation's plan represents a proposal for how the organisation intends to respond to patient safety incidents over a period of 24 months. The plan is not a permanent rule that cannot be changed. Organisations must remain flexible and consider each patient safety incident in light of the specific circumstances in which it occurred and the needs of those affected, as well as the plan.

Progress to date

Our plan has been developed following stakeholder engagement, including our PSPs and review of our patient safety incident profile and triangulation of this with a thematic analysis of multiple types of data to agree our local priorities. As part of this work, we reviewed existing improvement work and plans and were then able identify the gaps in our knowledge and understanding. These areas became our local priorities;

- Delays in escalation & deterioration management
- Harm from inappropriate care location
- Delay in diagnosis and /or treatment (ward rounds, handovers)
- Failure to act on results post discharge/outpatients

- Delay/omission of time-critical medication

We are now able to share our plan with UHL Board members for approval following approval at Patient Safety Committee on 17 March 2026 and Quality Committee on 27 March 2026. This is our second PSIRP.

An organisation's PSIRP must be agreed by the integrated care board (ICB), other commissioning leads where required, and the board of the organisation for sign-off. Finalised plans should be published on the organisation's external facing website alongside its patient safety incident response policy. We have refreshed our patient safety incident response policy which is going through the appropriate governance processes and when approved both the updated plan and policy will be added to our public website to replace the previous versions.

Once UHL Board approves this plan the final stage will be for approval at the ICB System Quality Group for formal system sign off.

This plan is a 'living document' that should be appropriately amended and updated as the organisation uses it to respond to patient safety incidents. Organisations are expected to review their plan every 24 months to ensure their focus remains up to date; with ongoing improvement work their patient safety incident profile is likely to change.

Recommendation

- UHL Board members to approve the UHL PSIRP in readiness for it to progress to the final part of governance process in line with national requirements.

University Hospitals
of Leicester
NHS Trust

Patient Safety Incident Response Plan 2026/28

Author:	Head of Patient Safety
Reviewer:	Patient Safety Committee
Approver:	Trust Board
Effective Date:	April 2026
Estimated Refresh Date:	April 2028

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Introduction

This patient safety incident response plan sets out how University Hospitals of NHS Trust (the Trust) intends to respond to patient safety incidents over a period of 2 years. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan is underpinned by our existing Trust policy on reporting, management, review and learning from incidents (B30/2024) and the Trust patient safety incident response policy (B16/2024).

Our Patient Safety Incident Response Plan (PSIRP) is integral to the implementation of PSIRF and aligns with the UHL vision to be leading in healthcare and trusted in communities and the strategic priorities; high-quality care for all; being a great place to work; partnerships for impact, and research and education excellence.
https://www.uhleicester.nhs.uk/about/trust/mission-vision-values/

This PSIRP is also a key part of Continuous Improvement Culture Development and supporting strategy which outlines how we will develop our Improvement culture across the Trust by placing the patient first when designing and improving our systems and services, whilst investing and developing our staff so our Trust can continue to improve.

UHL Strategic priority	PSIRF theme
High quality care for all	The PSIRF is all about improving patient safety and aligning this with quality improvement work, which is an integral part of quality and is at the forefront of everything we do.
Being a great place to work	The PSIRF includes a whole framework for meaningful engagement and involvement of patients, families and staff following a patient safety incident. We will be working on creating a just and restorative learning culture for staff when an incident occurs.
Partnerships for impact	In seeking those in-depth insights into our safety systems across the local healthcare system, PSIRF will help us reduce unwanted variation and feed those insights into continuous improvement work.
Research and education excellence	The essence of PSIRF is about building capability within all staff groups with the provision of the required patient safety training to be able to respond and learn from patient safety incidents. Consideration of research to support further understanding of our local priorities.

Our services

University Hospitals of Leicester NHS Trust (UHL/the Trust) was established on 1st April 2000, from a merger of three previously separate hospitals - Leicester Royal Infirmary, Glenfield Hospital, and Leicester General Hospital.

Our organisation is formed of seven Clinical Management Groups (‘CMGs’) that are supported by several corporate directorates. The Clinical Management Groups are:

- Cancer, Haematology, Urology, GI Medicine and Surgery
- Emergency and Specialist Medicine
- Musculoskeletal and Specialist Surgery
- Clinical Support and Imaging
- Renal, Respiratory and Cardiovascular
- Intensive/Critical Care, Theatres, Anaesthesia, Pain and Sleep
- Women’s and Children’s

The corporate directorates are:

• Corporate Medical
• Corporate Nursing
• Corporate Operations
• Finance
• People and Organisational Development
• Estates and Facilities
• Communications and Engagement
• Information Management and Technology
• Corporate and Legal Affairs
• Reconfiguration, strategy, transformation

The CMGs and corporate directorates are overseen by our Trust Leadership Team and Trust Board.

Aims and Objectives of PSIRF at UHL

There are four overarching aims of the Patient Safety Incident Response Framework (PSIRF) upon which this plan is based which support the development and maintenance of an effecting patient safety incident response system. Specific objectives have been set in order to ensure that we meet the overarching aims of PSIRF:

Figure 1. Overarching aims and objectives for PSIRF at UHL

Overarching Aims	Objectives
1. Compassionate engagement and involvement of those affected by patient safety incidents	• Develop a climate that supports a just and restorative learning culture and an effective learning response to patient safety incidents • Respond to patient safety incidents purely from a patient safety perspective • Support and involve staff affected in patient safety incident responses, for better understanding of the issues and contributory factors • Support and involve patients, families and carers in incident response, for better understanding of the issues and contributory factors, promoting Duty of Candour
2. Application of a range of system-based approached to learning from patient safety incidents	• Recognise that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component • There is no remit to apportion blame or determine liability, preventability or cause of death in a response to a patient safety incident conducted for the purpose of learning and improvement.
3. Considered and proportionate responses to patient safety incidents	• Transfer the emphasis from quantity of investigations completed with an arbitrary deadline to a higher quality response to patient safety incidents, and the implementation of meaningful actions that lead to demonstrable change and improvement

4. Supportive oversight focused on strengthening response system functioning and improvement	• Reduce the number of duplicate investigations into the same type of incident to reduce waste, enable more resource to be focused on effective learning and so enable more rigorous investigations that identify systemic contributory factors • Aggregate and confirm validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents • Consider the safety issues that contribute to similar types of incidents • Better measurement of improvement initiatives based on learning from incident response. • Develop system improvement plans across aggregated incident response data to produce systems-based improvements

Defining our patient safety incident profile

The Trust has a continuous commitment to learning from patient safety incidents and we have developed our understanding and insights into improvement workstreams over a period of years. We have a monthly Executive-led Patient Safety Committee and a Patient Safety Learning and Improvement Committee that allows triangulation of themes from incidents, learning from death reviews, patient feedback (complaints/PALS), inquests and claims.

In November 2025, we identified the period 1st April 2023 to 31st June 2025 for our thematic data analysis. Over a period of four months, we undertook a comprehensive analysis of our current patient safety risk profile across all services within UHL.

Stakeholder engagement

A collaborative stakeholder workshop was held in November 2025 that involved UHL and integrated care system (ICB) colleagues and one of our Patient Safety Partners to generate our second PSIR plan local safety priorities. The stakeholders presented their top themes, followed by discussion of what could be the agreed themes for our local priorities in the second PSIR plan. The following key themes were identified:

- Communication failures
- Delays and timeliness
- Medication safety
- Care fundamentals and dignity
- Handover and transitions of care
- Environment and flow
- Recognition and escalation

The stakeholder workshop culminated in producing a set of priority areas which required further discussion and refinement by the Patient Safety Specialists, taking into account current priorities and improvement to date. The next stage of the process was to engage with CMG colleagues to agree the focus for our improvement work and local PSIIs. This was completed by requesting feedback on a draft set of priorities from those staff that had attended the workshop.

Data sources

To define our patient safety response profile, we drew data from a variety of sources. The UHL patient safety risks were identified through the following data sources for 2023-25:

- Analysis of three years’ of Datix incident data (including prevented incidents)
- Detailed thematic analysis of learning themes from our PSIIs
- Key themes from complaints, PALS concerns, claims & inquests
- Key themes identified from specialist committees (e.g. deteriorating patient, falls, pressure ulcers)
- Themes from the Learning from Deaths reviews
- Key themes from medication safety incidents
- Key themes from the learning from MNSI investigations and perinatal mortality reviews
- Key themes from risks on the risk register
- Key themes from Infection Prevention incidents
- Key themes from Safeguarding reviews and LeDeR reviews
- Key themes from clinical audit

Where possible we have considered what any elements of the data tell us about inequalities in patient safety. As part of our workshop, we also considered any new and emergent risks relating to operational pressures and changes in demand that the historical data does not reveal.

Defining our patient safety improvement profile

Our patient safety improvement profile comes from a range of sources and includes:

- Existing Transformation Programme priorities
- Existing Patient Safety Improvement Programme priorities eg deteriorating patient
- Perinatal Safety Improvement Programme
- Trust-wide quality improvement projects registered on UHL Audit & QI Programme (AQIP)
- Trust-wide operational improvement work eg Criteria led discharge
- ICS operational improvement projects eg virtual wards
- National Patient Safety Improvement Programmes eg maternity and neonates improvement programme
- East Midlands Patient Safety Collaborative Programmes

We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Our patient safety incident response plan: national requirements

Given that the Trust has finite resources for patient safety incident response, we intend to use those resources to maximise improvement. PSIRF allows us to do this, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. For other types of incidents which may affect certain groups of our patients, a PSII will also be required. These have been determined nationally, but the Trust fully endorses this approach as it fits with our aim to learn and improve within a just and restorative learning culture.

As well as PSII, some incident types require specific reporting and/or review processes to be followed. For clarity, all types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods and are detailed in the table below:

Patient Safety Incident Type	Required Learning Response	Lead body for response
Incidents meeting the Never Event criteria	Patient Safety Incident Investigation (PSII) or proportionate response (interim consultation on Never Event framework guidance)	UHL
Incident leading to death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for PSII)	Patient Safety Incident Investigation (PSII)	UHL
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations Special Health Authority (MNSI) criteria.	Refer to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) for independent patient safety incident investigation	MNSI
Death of a person with learning disability	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death	LeDeR programme

Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria for PSII.	Child Death Overview Panel/UHL
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Patient Safety Incident Investigation (PSII)	UHL
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally led learning response	UHL
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence 2) adults (over 18 years old) are in receipt of care and support needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead via UHL Safeguarding Lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	UHL
Hospital acquired infections resulting in harm	Refer to Infection Prevention Team and use of appropriate learning response	UHL
Incidents meeting the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)	Refer to the relevant Medical Physics Expert and use of appropriate learning response	UHL

Incidents meeting criteria for reporting to the Human Tissue Authority (HTA)	Refer to designated HTA lead and use of appropriate learning response	UHL
Transfusion incidents meeting criteria for Serious Hazards of Transfusion (SHOT) reporting	Refer to designated Blood Transfusion lead and use of appropriate learning response	UHL

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our data insights, based on the review of incidents and stakeholder engagement process we have determined that the Trust requires 5 patient safety priorities as local focus. We have selected this number due to the breadth of services that the Trust provides. The local patient safety incident investigation (PSII) priorities link to the improvement priorities but are specific areas that we feel we would want to examine further to inform our improvement work by undertaking a PSII. This will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors that also featured as broader themes from our analysis work.

We will use the outcomes of PSIIs to inform our patient safety improvement planning and work.

UHL Local Priorities

Trust wide patient safety improvement priorities

Based on the thematic work undertaken, the following priorities for improvement are being undertaken. These areas represent key themes across multiple data sets, but also where we already have good insight into system contributory factors.

Priority	Definition	Executive Lead/Owner	Clinical/ Operational Leads	Known contributory factors	Improvement focus
1. Delays in escalation & deterioration management	**Improve early recognition and timely escalation for acutely unwell patients**	**Chief Nurse**	Deteriorating Patient Board Chair; Sepsis Leads; Heads of Nursing & Midwifery, Clinical Directors	Cultural and practical barriers to incorporating family and carer concerns.	Implementation of the three aims of Martha’s Rule - further clarity and communication on role and responsibilities
				Identification of sepsis can be challenging due to vague symptoms which can mirror symptoms of other conditions.	Development of adult and paediatric sepsis guidelines and training programmes. Skin perfusion made a mandatory observation

				There is limited oversight or assurance around patient monitoring outside of patient safety incident reports to provide a safety II and proactive approach to driving improvement.	To develop and implement a deteriorating patient performance dashboard based on the monitoring, recording, recognition and escalation of acutely unwell patients. Train staff on family/carer escalation pathways.
2. Harm from inappropriate care location	**Reduce risk from outlying patients and care in corridor care spaces**	**Chief Operating Officer**	UEC Transformation Board; Flow Managers; ED Clinical Leads; CMG Triumvirates	Patients with vulnerabilities being outlied and moved at all hours of the day and night	Set a ‘redline’ policy for night-time moves of vulnerable patients. Expand flow coordination teams and escalation protocols. Monitor crowding patient safety and experience metrics and corridor care usage. Implement real-time bed management tools.
3. Delay in diagnosis and /or treatment	**Ensure timely senior review and reliable**	**Medical Director**	Clinical Directors, Heads of Service; CMG	Unwarranted variation in ward round processes	EPR programme, aim to achieve a single patient record by 2028. Ward round checklist and time-bound senior review.

<table>
<tr><td>(ward rounds, handovers)</td><td>handovers that progress care</td><td></td><td>Q&S Leads; EPR Clinical Champions</td><td>Unwarranted variation in medical handover processes</td><td>Structured handover in EPR.
Implement use of SBAR.</td></tr>
<tr><td>4. Failure to act on results post discharge/out patients</td><td>Ensure timely review and actioning of test results after discharge or outpatient visits</td><td>Medical Director</td><td>Pathology & Radiology Leads; Clinical Directors; Heads of Service; ACP lead; EPR Team</td><td>Speciality unwarranted variation in results management</td><td>Implementation of order comms into outpatients. Consideration of implementing digital alerts and reminders in EPR. Assign clear accountability for result review. Regular audits and closed-loop communication checks. Consideration of how EPR patient portal can support results management.</td></tr>
<tr><td rowspan="3">5. Delay/omission of time-critical medication</td><td rowspan="3">Improve safe and timely administration of essential medicines (incl. anticoagulation)</td><td rowspan="3">Chief Pharmacist & Chief Nurse</td><td rowspan="3">Medicines Optimisation Committee; Ward Pharmacy Leads; Digital Medicines Team</td><td>Staff and patient knowledge of anticoagulation medication safety</td><td>Development of staff education programme.
Development of patient information (working with Patient Safety Partner)</td></tr>
<tr><td>Electronic prescribing system could provide better functionality to improve time critical medicine safety</td><td>Development work with E-Meds to provide solution for paused medications and a reminder to review medication</td></tr>
<tr><td>There is limited oversight or assurance around</td><td>Work to agree indicators and develop a medication safety dashboard.</td></tr>
</table>

				the administration of time critical medication outside of patient safety incident reports to provide a safety II and proactive approach to driving improvement.	
				Absence/inconsistency in standards for patient identification	Implement Scan4Safety for medicine administration into inpatient areas.

Local patient safety incident investigation (PSII) priorities (linked to our improvement priorities)

The following local patient safety incident investigation priorities represent specific safety challenges where the organisation does not have confidence it has comprehensive insight into the contributory system factors. These link to the improvement priorities but are specific areas that we feel we would want to examine further to inform our improvement work by undertaking a PSII.

Priority no.	Priority	Speciality	No. of PSIIs planned
1	Delays in escalation and managing deterioration of a patient linked to need to transfer cross site for care	All areas, including Maternity	1
2	Harm or potential for harm relating to a patient not being in appropriate care location due to significant operational pressures and/or crowding in ED	All areas, including Maternity	2
3	Delay in diagnosis or treatment of a patient with a focus on ward round, senior review and handovers	All areas, including Maternity	2
4	Failure to review/act on results after an inpatient discharge or outpatient appointment	All areas, including Maternity	2
5	Delay or omission in administration of time critical medicine for a vulnerable patient (eg dementia, end of life, mental illness)	All areas, including Maternity	2

Through all our PSIIs there will be two golden threads in our terms of reference: -

Communication - exploring communication between colleagues, areas, organisations and communication with patient and/or family members.

Empowerment – exploring how we could better empower the patient, family members and our colleagues.

Learning responses for other patient safety incidents (not agreed as local priorities for PSII)

Patient Safety Incident	UHL Planned Response	Oversight of themes & improvement work
Inpatient falls resulting in a bone fracture or haemorrhage	Immediate safety huddle and use of appropriate learning response	Falls Steering Group Harm Free Care Group Nursing, Midwifery and AHP Committee Patient Safety Committee
Healthcare associated pressure injury	Use of appropriate learning response	Harm Free Care Group Nursing, Midwifery and AHP Committee Patient Safety Committee
Hospital acquired infections resulting in death	Statutory duty of candour and use of appropriate learning response	Trust Infection Prevention and Control Committee
Maternity or neonatal incident with poor outcome (not meeting HSIB referral criteria)	Rapid review and use of appropriate learning response.	Perinatal Assurance Committee Quality Committee
Incident resulting in moderate or severe harm to patient	Statutory duty of candour and use of appropriate learning response	Patient Safety Committee
All other patient safety incidents	Validation of facts at local level by managers review or immediate safety huddle, local action and shared learning and/or use of appropriate learning response	Patient Safety Committee
Identified and emerging increase in incidence of subject of theme which has potential for harm or has caused harm	Thematic review or consider PSII	Patient Safety Committee

For any incident not meeting the PSII criteria, or any other criteria, we will use a proportionate learning response tool to enable a systems-based review. For lesser or no harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Appendix A - National Learning Response types

Patient Safety Review (PSR) Type	Methods	Objective
Incident recovery Immediate measures taken to: • Address serious discomfort, injury or threat to life • Respond to concerns raised by the affected patient, family, or carer • Determine the likelihood and severity of an identified risk	Immediate action	To take urgent measures to address serious and imminent: • discomfort, injury, or threat to life • damage to equipment or the environment.
	Risk assessment	To assess the likelihood and severity of identified hazards in order that risks can be determined, prioritised, and control measures applied
	Timeline mapping	To provide a detailed documentary account of what happened in the style of a 'chronology'
	Work system scan	A checklist and documentation tool to ensure the full breadth of the work system is considered. The tool is used to indicate any aspects of the system design that hinder or support people in the work system to do their job (ie barriers and facilitators).
Team reviews Post-incident review as a team to: • Identify areas for improvement • Celebrate success • Understand the expectations and	Debrief	An unstructured, moderated discussion The simplest and most informal method to gain understanding and insight soon after an incident (debriefs held

perspectives of all those involved • Agree actions • Enhance teamwork through communication and collaborative problem solving		immediately after an incident are known as 'hot' debriefs).
	Immediate Safety Huddle (Swarm huddle)	**Proactive**: a planned team gathering to regroup, seek collective advice, or talk about the day, shift, next few hours. Allows for on-the-spot assessment, reassessment, and consideration of whether there is a need to adjust plans. **Reactive**: triggered by an event to assess what can be learned or done differently. Focused on process-oriented reflection to find actionable solutions
	After action review	A 'cold' structured debrief facilitated by an AAR facilitator. AARs are based around four overarching questions: 1. What is expected to happen? 2. What happened? 3. Why was there a difference between what was expected and what happened? 4. What are the lessons that can be learnt?

Systematic reviews To determine: • The circumstances and care leading up to and surrounding the incident • Whether there were any problems with the care provided to the patient	Multidisciplinary team (MDT) tabletop review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
	Case note review (e.g. Structured Judgement Review)	To determine whether there were any problems with the care provided to a patient by a service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
	Mortality review	A systematic review of a series of case records using a structured or semi-structured methodology to identify any problems in care and draw learning or conclusions that inform action needed to improve care, within a setting or for a specific patient group, particularly in relation to deceased patients

	Specialised reviews	For example, falls, pressure ulcers, IPC reviews
Monitoring	Audit	Regular review to improve the quality of care by evaluating delivered care against standards. Can be observational or include documentation review (or both)
	Survey	Is the combination of questions, processes and methodologies that analyse data about others. It aims to determine insights about a group of people.
	Appreciative Inquiry	Is a positive-focused approach, which looks at what's going right in order to solve problems

Appendix B - Glossary of terms

PSIRF - Patient Safety Incident Response Framework

This is a national framework applicable to all NHS providers outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan

Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a collaborative approach with the CMGs and specialist process leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation

PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

AAR – After action review

A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review

Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

Immediate Safety Huddle - Used within Healthcare in the UK and US, an immediate collective or SWARM huddle approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis, take any required immediate actions and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

University Hospitals of Leicester NHS Trust

QC 26.3.26 Paper I

Meeting title:	**Patient Safety Committee**
Date of the meeting:	18th March 2026
Title:	UHL Annual Prevention Report 2024/25 - From Sickness to Prevention: Making it mainstream
Report presented by:	Dr. Ruw Abeyratne; Director of Health Equality and Inclusion
Report written by:	Dr Charlotte Grantham, Health Inequalities Fellow; Dr Ruw Abeyratne

Action – this paper is for:	Decision/Approval	x	Assurance	x	Update	
Where this report has been discussed previously	NA					

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

Risk 4315 – Health Equality and Inclusion: There is a risk of inequitable access to healthcare services and inconsistent navigation through care pathways for patients with protected characteristics (as per the Equality Act) and those from other populations due to social determinants of health, including but not limited to socioeconomic deprivation, employment status, and digital poverty leading to poorer health outcomes.

Impact assessment

Use this section to highlight any specific impact as a result of this report. You should think about:

- Patients - This report highlights implementation of prevention work leading to improved patient health outcomes through early detection and disease prevention.
- Workforce – one of the prevention priorities is workforce wellbeing. This report showcases the excellent work UHL undertakes to support colleagues to live healthier lives, reducing sickness absence and increasing productivity.
- Equality, Diversity & Inclusion – targeted prevention programmes can help reduce health inequalities. This report highlights populations that have benefited, particularly those from more deprived background or marginalised groups.
- Services –preventative interventions can reduce demand on hospital services by reducing avoidable hospital admission allowing better resources to be focused on patients that need them most.
- Finance – Effective prevention strategies can generate significant long-term savings while also providing social value to the local community.
- Reputation/legal – this report has received attention from other Trusts as a strong example of how an acute NHS Trust prioritises prevention demonstrating the Trusts ongoing commitment to prevention and enhancing its reputation.

Acronyms used:
ICB – Integrated Care Board; TB – Tuberculosis; BBV – Blood-borne virus; LLR – Leicester, Leicestershire & Rutland; AIDS – Acquired Immunodeficiency Syndrome; ED – Emergency Department; IMD – Index of Multiple Deprivation; HWB – Health & Wellbeing

Purpose of the Report

To seek approval for publication of the Prevention Report at the UHL Health Equality Summit.

To assure Patient Safety Committee on activity and impact related to the Trust's prevention priorities.

Recommendation

To approve the Prevention Report for publication at UHL Health Equality Summit.

To be assured the Trust continues to deliver significant prevention activity with measurable impact on patient outcomes and reducing demand on acute services.

Summary

The third annual UHL Prevention Report will be launched at the UHL Health Equity Summit on 15th April 2026. It highlights the Trust's prevention work, delivered internally and in partnership with the wider ICB and voluntary sector. Leicester is leading in its approach to prevention space in the acute sector and the report is increasingly recognised by other Trusts as a model for prioritising prevention within an acute NHS Trust.

This year's prevention priorities include Tobacco, Alcohol, Obesity (including childhood obesity), Tuberculosis, blood borne viruses and workforce wellbeing. The report concludes with reflections focusing on refining digital pathways, strengthening collaboration across the ICB and improving monitoring to demonstrate impact and secure ongoing investment.

Main report detail

The third annual UHL Prevention Report will be launched at the Health Equity Summit on the 15th April 2026. The report highlights the progress and impact of prevention activity across the Trust, delivered both internally and in partnership with the wider ICB and voluntary sector. It also presents key local population health data, identifying areas of greatest need and demonstrating that these services are not optional but essential if we are to effectively tackle health inequalities.

National policy continues to emphasise the importance of prevention, particularly through the 10 year health plan. This direction is reflected in Trust policies and strategic planning as outlined in the UHL Annual Report 2024-25 and the UHL-UHN Group Clinical Strategy 2025-2035. Leicester is pioneering in the prevention space, and this report is increasingly being recognised by other Trusts as a model for how a healthcare organisation can prioritise prevention. The outcomes presented in this report have demonstrated strong impact and confirm that UHL is well positioned to further develop this prevention agenda.

This year the report has been expanded to include a dedicated children's prevention chapter, focusing on childhood obesity. This reflects our commitment to giving every child the best start in life through early intervention and prevention.

The 2024/25 UHL Prevention Priorities presented in this report are detailed below along with a brief summary of each corresponding chapter.

- Tobacco
    - Adult smoking prevalence in Leicester is 9.8% overall, but as high as 16.5% in routine and manual workers. Last year, the service saw 4,186 patients with 44% engaging with a quit attempt which is estimated to have saved the Trust £561,384 due to reduction in 1 year readmissions.
    - Key developments included team expansion and improved follow-up data collection, offering an alternative stop smoking medication to our patients and secured innovation funding that enabled nearly 700 referrals from the Emergency Department.
    - A key challenge relates to maternity stop smoking services and how referrals are made to tobacco dependency services; while many trust's have an opt out referral system, UHL's remains an 'opt in' service due to data sharing barriers between the Trust and Local Authority.
- Alcohol
    - Despite most drinkers being low risk, men in Leicester experience higher rates of alcohol-related hospital admissions and deaths when compared to the national average.
    - The Alcohol Care Team delivered 1,658 brief interventions to patients. Their interventions reduced emergency admissions among frequently admitted patients by 28.6% and a cost-analysis estimated savings of £1.53-£3.36 for every £1 spent.
    - The team also delivers a fibro scanning service aimed at identifying liver disease early.
- Obesity
    - Around two-thirds of adults across LLR are overweight or obese, a pattern that is also reflected in the UHL inpatient population. T
    - he Tier 3 Weight Management Pilot Service has 478 active patients and has achieved an average weight change of 8.4% across the whole cohort.
    - Despite being highlight clinically effective the service is due to close in March 2026 due to a lack of further funding.
- Childhood Obesity
    - In Leicester, more than one in three children leave primary school overweight or obese.
    - The service has reviewed 223 children and young people to date with a high proportion of children from groups known to experience greater health inequalities.
- Tuberculosis (TB)
    - Leicester has the highest rate of TB in the country and cases are rising. Last year, GPs across LLR tested 1,554 through the migrant screening programme, 64% increase compared with 2022/23.
    - UHL's TB service assessed 315 people with suspected TB, treated 227 active cases and supporting 450 with newly identified latent TB infection.
- Blood-borne viruses

  - Many people with BBVs are diagnosed late, increasing the risk of transmission and serious health complications, such as AIDS-related illness, liver cirrhosis, and liver cancer. This contributes to higher morbidity, mortality, and healthcare costs.
  - At the time of writing, the ED Opt-Out Screening programme identified 118 new cases of BBV. 97% of Hepatitis B cases were new to service compared with 22% of HIV and 14% of Hepatitis C cases.
- Workforce Wellbeing
  - UHL employs just under 20,000 staff, making us one of the largest NHS Trusts in the country. The majority of our colleagues are female and nearly a quarter live in the 20% most deprived areas (IMD 1-2). The Health & Wellbeing service continues to provide a range of support services including a newly launched menopause support service. Findings from a workplace health needs assessments will inform HWB programme in 2026.

This report highlights the significant breadth of prevention work underway across UHL, involving a wide range of departments and stakeholders. Based on these findings, we suggest the following reflections and learning points to inform our work as we move into 2026.

1. Refine digital infrastructure to ensure prevention pathways are routinely offered to those who need them most.
   a. National policy emphasises the shift from analogue to digital. Streamlining pathways to ensure shared information, robust data collection and automatic signposting to services will help to reduce unnecessary duplication in the patient pathway.
2. Increase collaboration across the ICB footprint to support joined up system working, particularly with outpatient services and primary care.
   a. Improved communication between services enables faster patient support through shared information giving, opportunistic screening and effective signposting.
3. Continue to improve monitoring of impact for these services to bolster recurrent funding grants.
   a. In the context of NHS financial constraints, demonstrating positive outcomes through social impact and economic analysis is essential to secure ongoing investment.

The Prevention Report highlights the importance of having Population Health expertise ‘in house’. This would facilitate stronger links with ICB and Public Health in the local authority, development of a population health approach to service development and ongoing review of the impact and ROI of prevention in acute services.

Supporting documentation

The 2026 Prevention Report is appended in full to this paper.

University Hospitals of Leicester
NHS Trust

From sickness to prevention
Making it mainstream

UHL Annual Prevention Report 2024/25

Authors:
Dr Charlotte Grantham
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Foreword

‘An ounce of prevention is worth a pound of cure’

The Works of Benjamin Franklin (1840), Vol 1, 134

I am proud that we have embraced our responsibility of preventing ill health in the communities we serve, as clearly outlined in our latest prevention report.

By making prevention part of our everyday work, we have prevented countless heart attacks, strokes, infections, and hundreds of other medical problems that would have affected people and families in Leicester, Leicestershire and Rutland (LLR), most often experienced by those who are the least advantaged in our society.

In taking this stance, we have actively addressed the need to improve health equity and reaped the benefits of reducing health and social care demand, to reinvest the financial savings across our services.

Good things do not happen by accident. The progress described in this report is down to determined UHL colleagues working together with the LLR Integrated Care Board (ICB), primary care providers, local authorities, and voluntary sector partners. Behind the scenes, work to enable seamless pathways of care, case finding, digital integration, and the provision of medicines and services should not be underestimated. I thank all of those involved in these achievements.

Over the next year, we hope to consolidate and expand the work described in this report, providing more people than ever before with effective interventions by improving case finding and using digital technology.

We will not stop here with our work on prevention. Frankly, we cannot afford to do so, due to the rising number of people affected by preventable medical problems. The national ambition to ‘mainstream’ prevention, as a critical pillar of the 10 Year Health Plan for England, is entirely aligned to our objectives at UHL.

Richard Mitchell
Group Chief Executive

University Hospitals of Leicester NHS Trust and
University Hospitals of Northamptonshire NHS Group

At University Hospitals of Leicester NHS Trust (UHL), we know that prevention is not optional - it is central to creating a healthcare system that is sustainable, effective, and equitable. Guided by the Government's 10 Year Health Plan, we aim to embed and amplify prevention throughout our clinical pathways and in the delivery of our organisational strategy to improve outcomes, safety, and quality of care for all.

Health inequalities are unfair and avoidable, and they impact our patients today. They are concentrated in our most vulnerable communities and are made worse by reactive systems of care. By focusing on prevention, we can direct attention and resources to those at greatest risk - narrowing gaps, improving access and delivering better outcomes.

Impactful prevention requires a truly system-wide approach, with coordinated pathways, resource allocation, and strong partnerships across organisations. It is central to the success of Neighbourhood Health. By understanding and owning our contribution, we can ensure that patients receive the right care, in the right place, at the right time, while building a more effective, efficient, and equitable healthcare system.

With this in mind, we acknowledge all our partners in the making of this report and, more importantly, the successful delivery of these services. This would be impossible without their specific contribution, be it time, expertise, or access to funding.

Through embedding prevention into routine care - including smoking cessation, alcohol support, and weight management - we help our patients to make sustainable lifestyle changes and live healthier, longer lives.

Prevention is our opportunity - and our responsibility - to transform health, reduce inequality and secure a better future for the communities we serve.

Dr Ruw Abeyratne
Director of Health Equality and Inclusion

University Hospitals of Leicester NHS Trust

UHL prevention priorities

Health inequalities continue to grow across England, with a nearly 20-year gap in healthy life expectancy between the most and least deprived areas of England[1]. These disparities are driven by a range of factors influenced by the wider determinants of health, such as income, housing, environment, and education, as well as health-related behaviours such as smoking, alcohol use, poor diet, and access to healthcare.

The current government has set out a health mission built around three transformational shifts[2]:

1. **Hospital to community**
2. **Analogue to digital**
3. **Sickness to prevention**

Their ambition is to halve the gap in healthy life expectancy between the most and least affluent areas, and to raise the healthiest generation of children ever. To achieve this, the plan outlines preventive strategies, including helping people to stop smoking, and tackling obesity and alcohol-related harm.

Major structural changes lie ahead for the NHS, including NHS England being brought back into the Department of Health and Social Care, and the introduction of ICB clusters. When these changes are combined with unprecedented financial constraints across the health service, there is the potential to distract systems from embedding prevention into everyday practice. Despite these challenges, prevention funding has been provided in long-term ICB baseline funding, there is a commitment to prevention in the 10 Year Health Plan, and prevention priorities are specified in NHS medium-term planning guidance.

At UHL, we recognise that prevention is key to reducing health inequalities, and to reducing long-term demand on our services. We are proud to be publishing our third annual prevention report, which demonstrates our ongoing commitment to prevention as an acute trust, in collaboration with system partners including the ICB, primary care providers, local authorities and the voluntary sector. This commitment is also reflected in the growing emphasis on prevention within the Trust's policies and strategic planning, as outlined in the UHL Annual Report 2024-25[3] and the UHL-UHN Group Clinical Strategy 2025-2035[4]. The commitment to prevention can be seen in NHS datasets such as the 'Model Hospital', and will be available to provide assurance in governance frameworks between commissioners and providers.

In line with the 10 Year Health Plan and the direction set out in the reports above, we recognise the importance of including a dedicated children's prevention chapter for the first time, focusing on childhood obesity. This reflects our commitment to giving every child the best start in life through early intervention and prevention.

The 2024/25 UHL prevention priorities presented in this report are:

- **Tobacco**
- **Alcohol**
- **Obesity**
- **Tuberculosis**
- **Blood-borne viruses**
- **Workforce wellbeing**
- **Childhood obesity**

Local context

Across Leicester, Leicestershire and Rutland (LLR), we serve a diverse and growing population of around 1.1 million residents, according to 2021 census data[1]. Our footprint includes some of the most culturally rich urban communities in the country, alongside more rural market towns and villages. Leicester is one of the UK's most diverse cities, and is recognised as the UK's first plural city, where no single ethnic group forms a majority. In contrast, more rural areas across Leicestershire and Rutland have challenges in terms of ageing populations, people living with multiple long-term conditions, and access issues.

This year's report will focus on UHL services. However, we acknowledge the merging of health services with the University Hospitals of Northamptonshire NHS Group to form the UHL-UHN Group, which widens our reach to around 1.9 million residents and nearly 30,000 colleagues. This brings with it huge opportunity and responsibility, as anchor institutions, to support our communities with a wide range of health needs, expectations and lived experiences.

While many communities experience relatively good health, others, particularly in parts of Leicester, face some of the highest levels of deprivation in England. Updated measures of deprivation have recently ranked Leicester as the 12th most deprived local authority in England[2].

These inequalities influence how people access and use services, with lower uptake of preventative care such as screening, vaccination and chronic disease management, and a heavier reliance on urgent and emergency pathways. Over the last 12 months, those in the 20% most deprived neighbourhoods accounted for 21% of emergency attendances, compared to only 15% of overall inpatient admissions.

As a result, people living in our most deprived neighbourhoods experience poorer health outcomes and shorter healthy life expectancy than those in less deprived areas only a few miles away. For example, women living in Rutland can expect to live up to 13 years more in good health compared to those in Leicester[3].

Over the last 12 months, UHL has provided care to:

- **286,116 emergency attendances**
- **297,323 inpatients**
- **1,024,899 outpatients.**

By embedding prevention into every interaction - whether at admission, discharge, or an outpatient appointment - we can help individuals **stay well for longer, reduce avoidable ill health and provide health equity.**

You can download the previous UHL Prevention Reports by visiting:

https://www.uhleicester.nhs.uk/publications/prevention-report-2022-23/
https://www.uhleicester.nhs.uk/publications/prevention-report-2023-24/

Prevention in numbers

297,323
Admissions across UHL this year

1,848
engaged in a smoking quit attempt

~30% fewer annual ED admissions on average
for frequent attenders following an ACT* intervention

↑64% in TB testing
since 2022/23 for migrant screening

118 new BBV (Hep B, C & HIV)
identified through the ED Opt-out BBV Screening

223 children and young people
supported to lose weight

Tobacco

Tobacco addiction is the single largest preventable cause of ill health, disability and death in the UK, and accounts for half of the health inequality gap between the most and least advantaged in society.

Local context

In Leicester, smoking remains a significant public health concern. According to 2024 Fingertip data[1], adult smoking prevalence in Leicester is 9.8% overall, but as high as 16.5% in routine and manual workers. Figures from the 2024 Leicester Health and Wellbeing Survey[2] suggest that around half of smokers express a desire to quit.

Smoking is increasingly concentrated in the most deprived communities, contributing to widening health inequalities. The difference in life expectancy between smokers and non-smokers is around 10 years, regardless of wealth[3].

At UHL, there is a tobacco dependence treatment service, made up of five in-house tobacco dependency advisors working across all three hospital sites, five days per week. They receive opt-out referrals for inpatients identified as smokers, and provide bedside support, including nicotine replacement therapy and tablet pharmacotherapy and onward referral to community smoking cessation services (Live Well and Quit Ready). They also provide training on treating tobacco addiction to UHL colleagues.

Why does it matter?

The harmful effects of tobacco are widely acknowledged. It is a major risk factor for many diseases, such as cancer, heart disease, stroke, diabetes, and COPD.

Opt-out inpatient smoking cessation services are critically important for helping people to quit smoking, and are proven to improve health equity[4]. Hospitalisation creates a unique, high-impact opportunity for intervention, as patients are more motivated to quit smoking, especially if they have been admitted for smoking-related illnesses. These services will expand as part of the NHS' 10 Year Health Plan.

Smoking cessation services offer immediate access to support at the bedside and link patients directly with community services upon discharge. Patients are 37% more likely to quit if they receive intensive hospital-based cessation support with follow-up, compared to those who don't[5].

Highlights 2024/25

Between September 2024 and August 2025, the service saw 4,186 patients, of whom **1,848 (44%) engaged with a quit attempt.**

- The team saw 5% more inpatients compared to the previous year, which resulted in a **9% increase in quit attempts.**

Characteristics of those referred to the service are:

- **Male** (62%)
- **White British** (68%)
- **More deprived background** – 39% were in Index of Multiple Deprivation (IMD) deciles 1-3, with those in the most deprived decile accounting for 16% of referrals.

Of those that were seen, **just under half engaged in a quit attempt across all IMD deciles** (42-50%).

Team highlights include:

- **Team expansion** - this year, the team included an additional tobacco dependency advisor (funded by Leicester City Council), and an acting consultant in public health, to push forward quality improvement work
- **Introduction of varenicline** - the service is now able to offer varenicline alongside cytisine, another stop smoking tablet medication. Good partnership work across organisations allows patients to receive the full 12 weeks of varenicline from UHL as part of their discharge
- **Improved data collection** - the service is now texting patients to see how their quit attempt is going five to six weeks after their admission. As a result, the service is now recording approximately 50% more quits than in previous years
- **Innovation funding to expand outpatient referrals** - The service has received innovation funding from NHS Midlands to expand the existing outpatient referrals from lung cancer clinics to community stop smoking services. This funding has also allowed the team to expand into the Emergency Department (ED). Between July and November 2025, 681 referrals were made from ED to the services

Using the ASH Tobacco Dependence Treatment Service Impact Calculator[6] we are able to estimate return on investment over the last 12 months in which **1,848 patients set a quit date,** resulting in:

83
reduction in all-cause 30 day A&E presentations

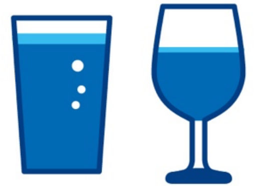
3 bed spaces
created per day, based on 1 year readmissions

216
reduction in all-cause 1 year readmissions

113
lives saved in a year

~£561,384
saved due to reduction in 1 year readmissions*

**estimates based on average cost of a UHL admission*



Alcohol

Alcohol use is responsible for 10% of the UK burden of death and disease, making it the third biggest modifiable risk factor.

Local context

According to the Leicester Health and Wellbeing Survey (2024), more than half of Leicester's population do not drink alcohol (55%)[1], which is significantly higher than the national average of 19%[2]. Despite this, alcohol-related harm remains a concern.

Despite most drinkers being low risk, men in Leicester experience higher rates of alcohol-related hospital admissions (2,928 per 100,000, compared to the national average of 2,837) and deaths (73.5 deaths per 100,000, compared to the national average of 59.5)[3].

For 2023/2024, the Leicester alcohol-related admission rate per 100,000 people was similar to the national average of around 1,831, whereas Leicestershire and Rutland continue to see significantly lower rates compared to the national average[3].

At UHL, we have an in-house alcohol care team (ACT) consisting of one band 7 nurse, three band 6 nurses, three Turning Point advanced recovery practitioners, a Turning Point recovery practitioner and a senior data analyst. The team is based at the Leicester Royal Infirmary, and receives referrals across all three hospital sites, seven days per week.

Why does it matter?

ACTs provide early, specialist intervention during admission. They provide brief interventions, initiate detox or treatment plans, and ensure follow-up through community services.

It has been found that ACTs can **reduce unplanned hospital admissions by up to 42%** and cut bed days by 39%[4]. They are also highly cost-effective, saving the NHS an estimated £3 for every £1 invested[5].

Alcohol-related harm is significantly higher in deprived communities, even though alcohol consumption levels are often similar to those in less deprived areas. This pattern is known as the ‘Alcohol Harm Paradox’[6].

People living in the most deprived areas in England are twice as likely to die from alcohol-specific causes[6] and to be admitted to hospital for alcohol-related conditions. This inequality is influenced by a combination of factors, including limited access to healthcare and support services, greater exposure to other health risks, psychosocial stress, and the impact of poverty on long-term alcohol use.

Highlights 2024/25

Between October 2024 and October 2025, ACT received **3,018 alcohol-related referrals** for 1,768 patients and provided **1,658 completed brief interventions** – around 126 interventions per month.

Of these referrals:

- 48% were already known to Turning Point and have an assigned key worker
- 16.3% were referred into Turning Point
- 35.7% were not referred

Most referrals received are via Nervecentre (40%), followed by ACT identifying referrals from wards (20.4%), telephone calls (15.1%) and ICE referrals (11.7%).

Characteristics of those referred to the service are:

- **Male** (71.8%),
- **Over the age of 45** (around 60%)
- **White British ethnicity** (60.2%).
  - The second most represented ethnic group among ACT referrals is Asian or Asian British (11.6%).
- **More deprived backgrounds** - IMD deciles 1-3 (40.9%)

For patients with a high number of admissions (at least one emergency admission every two months, or a total of six in a year) who are referred to ACT, we have seen a **decrease of 28.6%** (from 8.4 to 6.0) in average emergency admissions per year following an ACT intervention.

The **fibro scanner service** aims to identify liver disease early. From August 2025, the team have been scanning between four and five patients per month on average.

A cost-analysis evaluation, using the benefit cost ratio from a minimum case model, found that ACT was cost-saving for the first two financial quarters of 2025 (without September data). On average, between April and August 2025, every £1 spent on ACT generated between £1.53 - £3.36 worth of savings.

Obesity

Around two in three adults across Leicester, Leicestershire and Rutland are overweight or obese.

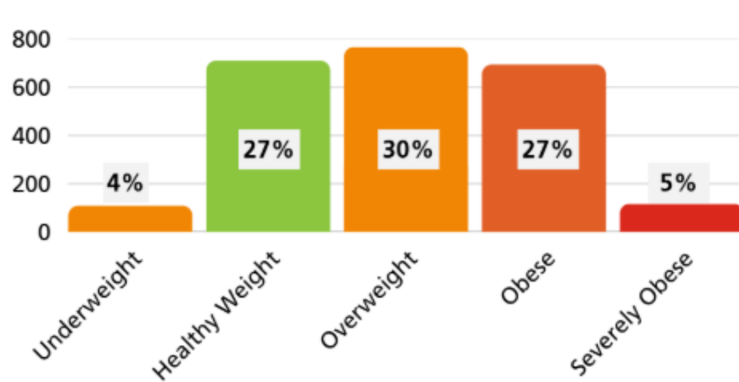
Local context

Obesity remains a significant public health challenge across Leicester, Leicestershire and Rutland (LLR). In 2023/2024, around two in three adults (65.2%) were classified as overweight or obese, which is a similar rate to the national average of 64.5%[1]. This presents a major concern given the strong association between obesity and chronic conditions such as type 2 diabetes, cardiovascular disease and certain cancers[2].

A similar trend is evident among children. In the early years of primary school, approximately one in five reception-age children in LLR are already overweight or obese. By Year 6, this figure rises to around one in three (34.8%), highlighting how excess weight becomes increasingly established as children grow older[1].

Furthermore, there is a pronounced obesity-deprivation gradient across the population. Children living in the most deprived areas experience obesity rates around twice as high as those in the least deprived areas[3]. This stark inequality underscores the need for a targeted and proportionate approach, directing greater investment and preventive action toward those communities most affected by the wider social determinants of health.

A snapshot across UHL inpatients for seven days in October 2025 showed that just one in four patients were of a healthy weight, according to BMI (N=2,587 patients).



Why does it matter?

It is well documented that obesity increases the risk of chronic health conditions such as type 2 diabetes, heart disease, and certain types of cancer[2]. It also has adverse psychosocial consequences and significant economic impact, with obesity and excess weight estimated to cost the NHS around £12 billion per year, and the total impact on the economy and wider society reaching around £126 billion[4].

In the hospital setting, we know that those who are obese are more likely to have longer hospital stays[5-6], higher risk of complications[7] and healthcare costs[5]. A moderate weight reduction of 5-10% is associated with health benefits, including reducing the incidence of certain cancers and type 2 diabetes, as well as improved quality of life and reduction in mortality[8].

Highlights 2024/25

NICE approved tirzepatide for the treatment of obesity in 2025, with an expectation that it would be made available to patients in 2025-26 across England. Each ICB was asked to inform NHS England how the medication would be made available to patients.

As of June 2025, the LLR ICB made the decision to use a community-based model for the roll-out of tirzepatide, providing the medication to people with a BMI greater than 40, with at least five pre-specified comorbidities. Tier two weight loss referrals to digital weight loss service providers are made by GPs for patients with a BMI of greater than 30 (or BMI greater than 27 for some ethnicities), and comorbidities of either diabetes, hypertension, or both.

The UHL tier three pilot service has 478 patients actively involved in the service. Those in the service have received wraparound care, including psychology, diet, physical activity, and medical treatment such as pharmacotherapy.

Findings from the service show that:

- There has been an average weight change of 8.4% for the whole cohort using tier three services, although this is significantly greater in the pharmacotherapy group (-12.2%) compared to non-pharmacotherapy (-3.9%)
- Psychological treatment increased confidence, reduced emotional eating and reduced binge eating
- Physical activity (Steps4Health) – patients saw an increase of 974 steps per days on average over the first six weeks, nearly double the minimum clinically important difference of 500 steps per day (Herring et al, 2025)
- 172 patients are currently being prescribed pharmacotherapy
- Patient feedback indicated improvements in mental and emotional wellbeing, as well as improvement in energy levels, blood pressure, or other health markers
- Overall, outcomes indicate that this person-centred approach is popular and clinically highly effective

However, the tier three pilot service has not received further funding and is therefore due to close in March 2026.

UHL tier four bariatric surgery

There were 45 bariatric operations in 2024, less than half the number of operations carried out in 2023 (103). Of these, 26 were performed at UHL, and 19 outside of the Trust.

Childhood obesity

Currently, one in three children leave primary school obese.

Local context

Childhood obesity is one of England's most pressing public health challenges, with around one in three children leaving primary school obese. In Leicester, rates are even higher, with 38% of Year 6 pupils classified as overweight or obese[1]. Obesity remains strongly linked with deprivation, and inequalities continue to widen.

While multifactorial, excess weight ultimately reflects an imbalance between energy intake and expenditure. Locally, only 19% of children meet recommended fruit and vegetable targets, and more than a third complete less than 30 minutes of daily physical activity[1].

The Leicester Complications of Excess Weight service provides a specialist, child-centred pathway focused on early identification and coordinated management of obesity-related complications. The model combines paediatric medical assessment, metabolic screening, psychology input, physiotherapy, dietetics, and links with community services to ensure integrated, timely care.

Key features

1. Early clinical risk stratification
2. Comprehensive metabolic complication screening
3. Integrated paediatric psychology support
4. Coordinated management of multiple comorbidities
5. Personalised care plans aligned with community provision

Why does it matter?

Childhood obesity has immediate health consequences, as well as future risks. Children and young people with excess weight may develop early complications such as type 2 diabetes, hypertension, fatty liver disease, sleep-disordered breathing, musculoskeletal pain, and reduced respiratory function. These conditions can begin during primary school and progress rapidly if unsupported.

Obesity also impacts mental health, school attendance, physical activity, and social participation, contributing to bullying, low self-esteem, and emotional eating. The impact is greatest in deprived communities, widening existing health inequalities and increasing demand across paediatric services including diabetes, hepatology, respiratory/sleep, orthopaedics, and Child and Adolescent Mental Health Services (CAMHS).

The service has reviewed 223 children and young people to date. The cohort includes a high proportion of children from groups known to experience greater health inequalities:

- 18.4% are of Asian ethnicity
- 29.1% live in areas with a deprivation score greater than four, and a further 22.9% live in areas with a deprivation score of three to four
- Neurodiversity is common, with 23% of the patients having a recorded neurodevelopmental diagnosis
- Almost half (42.5%) have one or more complications related to excess weight, illustrating the significant clinical and psychosocial complexity within the service

Clinical outcomes show sustained improvement. The overall mean BMI standard deviation score (SDS) reduction is -0.23, representing a clinically significant change. Among those prescribed semaglutide, the mean BMI standard deviation score reduction is -0.32, with an average absolute BMI reduction of 3.8 kg/m^2.

These findings show that a multidisciplinary, person-centred model combined with pharmacotherapy can achieve meaningful benefits for children and young people with more severe obesity or obesity-related comorbidities.

The service has confirmed funding until March 2027. Due to the long waiting list and current capacity constraints, referrals are temporarily paused while existing caseloads are managed safely. Alongside this, a system-wide weight management strategy is being formulated across LLR, to ensure a coordinated, equitable and sustainable pathway for children, young people and adults.

Overall, the children and young people’s weight management service continues to reach a diverse, high-need population and deliver measurable clinical benefits, while contributing to the development of longer-term system solutions for obesity care across the region.

Tuberculosis

Leicester currently has the highest rate of tuberculosis in the country, and cases are rising.

Local context

There has been a steady rise in tuberculosis (TB) cases across the UK as communities have emerged from the pandemic. TB notification numbers in England saw a significant rise of 13.6% in 2024, compared to 2023, which is the largest annual increase since national surveillance began. The rate of TB incidence is currently 9.4 per 100,000[1]. If the rise in rate continues, England will pass the World Health Organization threshold of 10 for a low incidence country by the beginning of 2026.

In 2024, cases increased in Leicester to 42.1 cases per 100,000, compared to 40.7 the previous year, making it the **highest TB rate in the country[1]**. A critical factor contributing to the rise in cases is increasing migration from high TB prevalence countries. In 2024, 93% of the active TB cases in Leicester were foreign-born people[2].

Despite ambitious prevention programmes since 2016, and with migrant numbers increasing since 2020, even more robust screening and treatment programmes are essential in preventing further spread.

Why does it matter?

TB is both preventable and curable. Despite this, it remains an increasingly significant public health challenge.

TB is a disease that spreads easily, causing severe illness in the acute phase, which requires prolonged hospital treatment and causes significant healthcare costs. It not only has significant impact on morbidity and mortality for those infected, but also poses a wider risk to vulnerable patients within the hospital, as some of those at risk of TB or with latent TB infection (LTBI) are working within healthcare services.

Preventing and treating TB at an early stage is significantly more cost-effective. TB can be latent for years before becoming active, and 5-10% of those with LTBI will go on to develop TB disease. Screening to detect LTBI is effective at preventing future disease and is a critical part of TB prevention. In high-risk populations, up to one in five people will be positive for LTBI when screened[1].

TB disproportionately affects disadvantaged communities and minority ethnic groups, populations that are particularly prevalent in Leicester, Leicestershire and Rutland. By focusing on prevention, we can deliver safer, more equitable, and more sustainable care for all.

Highlights 2024/25

LTBI across LLR

The national LTBI testing and treatment programme has been running since 2015 in local authorities where incidence is high. It aims to test new entrants to the UK, but was heavily impacted by the COVID-19 pandemic. It is available for all new entrants who:

- Have entered the UK in the past five years
- Have lived in sub-Saharan Africa, or a country with a TB rate greater than or equal to 150 per 100,000, for at least six months
- Are between 16 and 35 years of age

An audit of the LTBI programme showed a decline in screening after 2019, with large variation across the city (Leicester City Health and Wellbeing Board update on TB, June 2024).

In 2024/2025, the total number of tests conducted by GPs in LLR as part of the migrant screening programme was 1,554, 237 (15.2%) of which were positive. LLR testing in migrants has increased by 64%, compared to 2022/23.

Overall, in 2024, 28.9% of LTBI cases were identified through new entrant screening, followed by occupational health (25.1%) and contact tracing (21.6%).

Completion rates for LTBI treatment remain above 90%.

UHL TB services

UHL's TB services are managed jointly between respiratory medicine, infectious diseases, and paediatrics. In 2024, the TB rapid access clinic at the Glenfield Hospital assessed 315 people with suspected TB.

- **227 active cases** of TB were diagnosed and treated
- **450** people with newly identified LTBI were supported (up 78% since 2022)

Blood-borne viruses

The World Health Organization has set out strategies to end AIDS and viral hepatitis epidemics by 2030.

Local context

Blood-borne viruses (BBVs) such as HIV, hepatitis B and hepatitis C spread through blood or bodily fluids containing the virus. Some people have no symptoms, while others become seriously unwell.

The World Health Organization aims to end AIDS and viral hepatitis as public health threats by 2030[1], and the UK has committed to achieving this through stronger prevention, testing, and treatment.

Nationally, new HIV diagnoses have fallen by 4% this year, with high treatment and viral suppression rates[2]. However, Leicester continues to face greater challenges. The city's diagnosed HIV rate in 2024 was 2.81 per 1,000, well above the national average of 1.77, and its new diagnosis rate is 14.4 per 100,000, compared with nine per 100,000 nationally[3].

England has made major progress on hepatitis C, with chronic infections falling by about 57% over eight years due to effective testing and treatment[4]. In contrast, hepatitis B remains harder to tackle. Current progress is too slow to meet the 2030 diagnosis and treatment targets, and emergency department (ED) opt-out testing has revealed a substantial number of previously undiagnosed cases[5], highlighting the need for further action.

Why does it matter?

Many people with BBVs are diagnosed late, which increases the risk of transmission and leads to more serious health complications, such as AIDS-related illness, liver cirrhosis, and liver cancer. This results in increased morbidity, mortality, and healthcare costs.

The NHS opt-out testing programme in EDs demonstrates the crucial role that hospitals play in BBV prevention. EDs now account for around 50% of all BBV testing nationally[5] and have identified substantial numbers of new diagnoses, particularly for hepatitis B, allowing patients to access lifesaving treatment earlier. Funding for this programme has been extended to 2029.

Acute hospitals see many high-risk individuals who may have limited contact with GP or community services, including sexual health clinics, where traditional BBV testing is offered. As the programme uses automatic testing alongside routine bloods, individuals do not need to self-identify as 'at risk', or disclose sensitive behaviours. This reduces stigma, removes barriers associated with risk-based testing, and helps to address health inequalities by reaching populations who might otherwise remain undiagnosed.

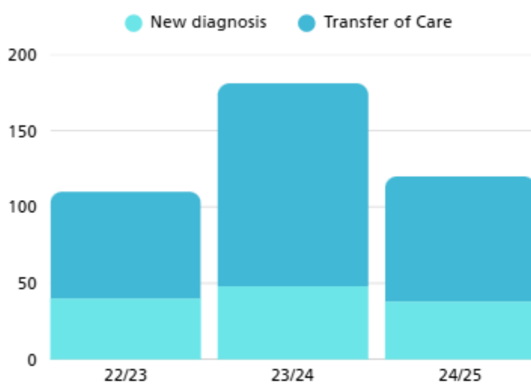
Highlights 2024/25

HIV services at UHL

The HIV service at UHL currently cares for a cohort of **1,688 patients** (a decrease of around 6% compared to 2024).

Between April 2024 and April 2025, there were **120 new HIV patients** (fewer new cases compared to last year).

- **38** new diagnoses
- **82** transfers of care from abroad or from other UK sites



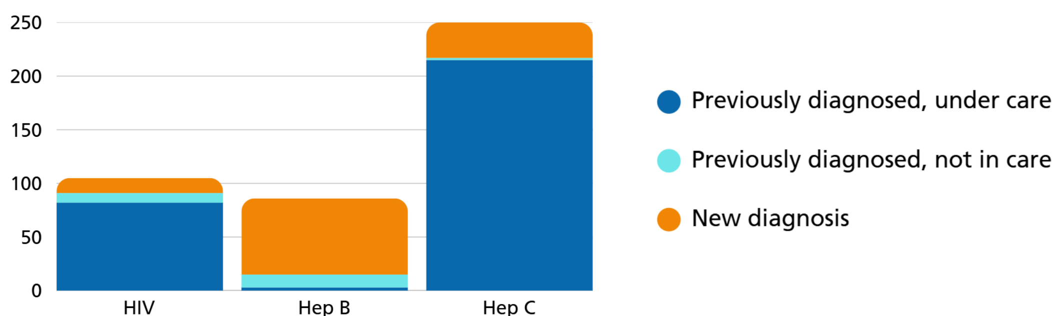
ED opt-out BBV screening programme

UHL rolled out ED opt-out BBV screening at the Leicester Royal Infirmary at the end of November 2024, as part of the national programme.

Between November 2024 and October 2025, ED BBV testing identified:

- **14** new cases of HIV and **9** previously diagnosed but not in care
- **71** new cases of hepatitis B and **12** previously diagnosed but not in care
- **33** new cases of hepatitis C and **2** previously diagnosed but not in care

ED screening has uncovered a substantial number of previously undiagnosed hepatitis B cases. **97% of cases** were new to service, compared to 22% for HIV and 14% for hepatitis C.



Workforce wellbeing

UHL is one of the largest employers in Leicester, Leicestershire and Rutland, with more than 19,000 employees.

Local context

Staff are the NHS' greatest cost and greatest asset, making workforce wellbeing a top priority. Aside from the moral and ethical imperative, there are compelling arguments that prioritising workforce wellbeing improves efficiency, productivity, and patient experience and outcomes. With the NHS representing Europe's largest workforce, supporting colleagues is also an investment in the health of the population[1].

The 10 Year Health Plan for England[2] acknowledges the need to improve staff health and wellbeing, including new standards to improve healthy work conditions, and offering a high-quality occupational health service for all NHS colleagues. Creating healthier workplaces will enable colleagues to stay well and in employment, aligning with the mission to shift from treatment to prevention.

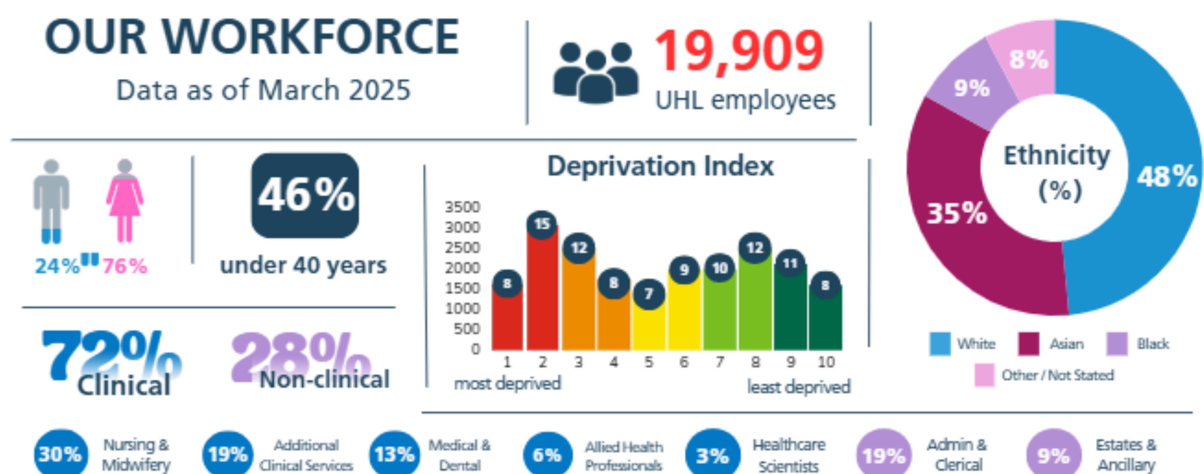
At UHL, we have a workforce of **19,909**, making us the one of the largest NHS trusts in the country. The majority of our colleagues are female, and 46% are aged under 40 years. Just over half of our colleagues are from ethnic minority backgrounds, and nearly a quarter (23%, 4,622 employees) are from the 20% most deprived areas (IMD deciles 1 and 2). The workforce grew by 4% from March 2024 to March 2025.

Why does it matter?

Nationally, the health of the working age population is deteriorating, with a record number of people out of work due to ill health[3]. This not only places a significant burden on the NHS and public services, as well as the UK economy, but also greatly impacts on individuals' quality of life.

Being in good employment has a positive impact on your health, and good health enables people to participate in the workforce. Turned the other way, the longer a person spends out of work, the greater the impact it has on their future employment and pay, reducing their standard of living, and resulting in further deterioration of health. Unemployment and poor-quality work are therefore major drivers of health inequalities.

Highlights 2024/25



- **UHL colleagues can self-refer to physiotherapy** via UHL Connect. From October 2024 to 2025, this service saw 524 staff members and received excellent feedback, with an average satisfaction rating of 4.9 out of 5.
- UHL has committed to the **NHS Healthy Weight Declaration,** enabling the Trust to embed a preventive approach to healthy weight.
- The **UHL menopause support service** was launched to provide colleagues with confidential, accessible, and culturally sensitive support.

- In summer 2025, 875 colleagues completed the Workplace Health Needs Assessment, helping us to understand areas to improve the health and wellbeing of colleagues. The results will inform the health and wellbeing work programme in 2026.
- The health and wellbeing service continues to offer physical activity sessions, mental health prevention and signposting to alcohol and substance misuse services.

Summary and reflections

This report highlights the significant breadth of prevention work underway across UHL, involving a wide range of departments and stakeholders. The outcomes presented in this report have demonstrated strong impact and are closely aligned with the national priority to shift from treatment to prevention. As the 10 Year Health Plan for England is introduced, with a major focus on embedding prevention services within hospitals and local systems, UHL is already well positioned to further develop this agenda.

As we enter new collaborative arrangements with the LLR ICB and clustered hospitals, it is important to remain consistent in our approach towards providing prevention pathways. Such an approach is critical to reducing health inequalities and demand on our services, enabling our population to maintain the best possible health.

We therefore suggest the following reflections and learning points to inform our work as we move into 2026.

1. We need to continue **to refine our digital infrastructure,** to ensure that prevention pathways are routinely offered to those who need them most.
    a. National policy has identified the need to move from analogue to digital, to provide more personalised and coordinated care to our patients. This includes joined up working with colleagues in community and primary care, to avoid duplication when it comes to collecting information on patients' health behaviours. Streamlining pathways to ensure shared information and automatic signposting to services will help to remove unnecessary steps in the patient pathway.
        i. Example: The 'Making Every Contact Count' assessment is well established in the electronic patient record, enabling efficient signposting and referral for those who need support. We could refine the assessment to include other relevant measures, such as BMI, which could include automatic text referrals to tier two digital weight management services for those over a certain BMI.
2. **Increased collaboration across the ICB footprint** to ensure joined up system working, particularly with outpatient services and primary care.
    a. As an acute trust, our colleagues have thousands of contact points with patients, offering powerful opportunities to provide proactive support.

With greater communication between services, we can accelerate patient support via shared information giving, opportunistic screening and signposting.

i. Example: Use the discharge summary to alert primary care to high-risk patients, and for personalised signposting to community services relevant to patients' needs. For example, including BMI, smoking and alcohol status on all discharge summaries, with offers of support.

3. Continue to **improve monitoring of impact** for these services, to bolster recurrent funding grants.

    a. Given the financial constraints on the NHS, it is important to be able to show the positive change our work is having through social impact and economic analysis. It is important to be able to work on appropriate outcomes that we can measure annually in the form of a live dashboard.

        i. Example: an economic cost-effectiveness model that we could design into a dashboard to provide real-time feedback of services and be able to see what works and what doesn't.

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