University Hospitals of Leicester NHS
NHS Trust

Trust Board paper H2

Meeting title:	Trust Board
Date of the meeting:	12 November 2026
Title:	**Escalation Report from the Finance and Investment Committee (FIC): 28 October 2026**
Report presented by:	Andrew Inchley, FIC Non-Executive Director Chair
Report written by:	Andrew Inchley, FIC Non-Executive Director Chair

Action – this paper is for:	Decision/Approval	X	Assurance		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 03 (Finance) and 05 (Estate)						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Finance and Investment Committee (FIC).

Summary

FIC met on 28 October 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 FIC's level of assurance.

There is 1 item requiring formal recommendation to the Trust Board from the October 2026 FIC meeting.

This escalation report follows a 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 escalation report also sets out any items recommended for Trust Board approval, and any items referred to other Committees.

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

Key escalations to notify to the Board	Actions to take outside of the committee
None	None
Positive Assurance taken	**Decisions taken**
• Financials – At M6, YTD deficit still favourable to plan, but note increased phasing of CIP through Q2-4 and required improvement in normalised run rate. Cash being closely monitored and managed, with detailed outlook with/without deficit funding due in November FIC. Moderate assurance – good results YTD and issues well understood, but still a material gap to plan looking forward and limited opportunities to mitigate. • Annual fire report – comprehensive report covering incidents over the year and progress on compliance actions. Priority list capital items identified and progressing/under discussion, work needed to improve annual fire training completion from 89% to 95%, effective response to compliance issues but lessons learned highlights importance of fire safety team input to any design decisions. Moderate/significant assurance – need to ensure priorities are incorporated into capital budget.	
Items recommended for Board approval:	
Fire annual report (appended)	
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:	Finance and Investment Committee					
Date of the meeting:	28 October 2026					
Title:	Fire Safety Management Annual Report (1st April 2025 to 31st March 2026)					
Report presented by:	Robert Hill – Head of Fire Safety					
Report written by:	Robert Hill – Head of Fire Safety Shannon Basi – Personal Assistant					
Action – this paper is for:	Decision/Approval	✓	Assurance	✓	Update	
Where this report has been discussed previously	N/A					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The aim of this report is to seek approval and provide assurance to the Board that essential fire safety compliance standards are maintained and that any key significant risk areas are identified and escalated via the appropriate governance routes within the Trust for the appropriate action and mitigation where reasonably practicable.

Impact assessment
▪ Patients and Workforce: Life safety, property protection and business continuity ▪ Increased Financial spending ▪ Reputation/legal – National press interest.

Acronyms used:
LFRS – Leicestershire Fire and Rescue Service
FSO – Fire Safety Order
FRA – Fire Risk Assessment
FSA – Fire Service Attendance
FSSO – Fire Safety Specialist Officer
UwFS – Unwanted Fire Signals (“False Alarms”)
BSA – Building Safety Act
AE (Fire) – Authorising Engineer for Fire
CFRS – Cambridgeshire Fire & Rescue Service
NFRS – Northamptonshire Fire & Rescue Service.

Purpose of the Report

The purpose of this report is to inform the Trust Governance and all other stakeholders or interested parties of the current position in relation to the Fire Safety provision in all Trust premises. The report also indicates where further fire safety related improvements are required.



Fire Safety Management

University Hospitals of Leicester

Annual Report (1st April 2025 to 31st March 2026)

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1 Assurance & Governance

The Trust Board retains overall accountability for fire safety, with executive oversight provided through the Director of Estates, Facilities and Sustainability, supported by the Fire Safety Committee and specialist fire safety team. Quarterly governance meetings continue to monitor compliance, risk and performance.

A significant development during the year was the appointment of DRLC as Authorising Engineer (Fire), providing independent external assurance of fire safety management arrangements. The first independent annual audit was commissioned for Quarter 1 of 2026/27 and will provide additional assurance to the Board regarding compliance maturity and future improvement priorities.

Board Assurance Rating:

Fire Safety Governance ○ Substantial
Fire Risk Assessment Programme ○ Substantial
Fire Service Regulatory Compliance ○ Substantial
Staff Fire Training ○ Moderate
Fire Safety Infrastructure ○ Moderate
Capital Risk Management ○ Moderate
Community & Satellite Sites ○ Substantial

2 Introduction

This report provides assurance to the Trust Board and Governance Committees regarding fire safety management arrangements across University Hospitals of Leicester NHS Trust (UHL) for the period 1 April 2025 to 31 March 2026.

The report demonstrates that robust fire safety management systems remain in place across Trust-owned and managed premises, whilst identifying key risks, priorities and improvement activities required to maintain statutory compliance and reduce residual fire-related risk.

During 2025/26 the Trust maintained compliance with core fire safety legislation through delivery of fire risk assessments, staff training, fire safety governance arrangements, support to capital projects and ongoing fire safety assurance activity.

3 Executive Summary

During the reporting year, significant progress has been made in strengthening fire safety governance, assurance, and operational resilience across the Trust. The

Fire Safety Team has continued to support compliance activities, risk reduction initiatives, staff training, and capital developments while responding to emerging risks and regulatory requirements.

Key achievements included the completion of 156 Fire Risk Assessments (FRAs) and reviews, ongoing support to major capital projects across all Trust sites and community locations, and the delivery of specialist fire safety training to 1,064 staff members covering evacuation procedures, fire warden responsibilities, and evacuation aids.

Annual fire safety training compliance reached 89% by the end of the reporting period.

External assurance remained positive. A total of ten Fire and Rescue Service audits were undertaken, with nine achieving a broadly compliant outcome. One audit at the East Midlands Planned Care Centre (EMPCC) identified deficiencies relating to cross-corridor fire doors; however, the required remedial actions were completed, and no further enforcement action was necessary. A Restriction Notice issued at the Peterborough Dialysis Unit in June 2025 was successfully lifted in December 2025 following completion of the necessary corrective works.

The Trust has taken proactive steps to strengthen fire safety governance through the appointment of DRLC as the Trust's Fire Authorising Engineer, with a comprehensive Fire Safety Management Audit scheduled for the first quarter of the next reporting year. In addition, new protocols are being developed to address the increasing risks associated with lithium-ion batteries, particularly in relation to the use and storage of e-bikes and e-scooters on Trust premises.

Operationally, the Trust experienced 11 fire incidents during the year, two of which required significant Fire and Rescue Service attendance. Unwanted Fire Signals (UwFS) remain a key challenge, with 309 false alarms recorded, resulting in 76 Fire Service attendances. Although Leicester Royal Infirmary accounted for the majority of UwFS events, effective local controls ensured only a limited number required Fire Service response. A significant proportion of false alarms continued to be caused by accidental or malicious activation of manual call points.

Fire safety risk management remains a priority area. There are currently 57 fire-related risks recorded on the Estates and Facilities Risk Register, of which 31 are categorised as high risk. Capital investment priorities have been reviewed, with the replacement of the Glenfield Hospital fire alarm system identified as the highest priority project. Work is also progressing to evaluate the replacement of existing foam and CO_2 extinguishers with a standardised P50 water-spray extinguisher solution, supporting sustainability, operational efficiency, and alignment with practices already adopted by neighbouring NHS organisations.

Looking ahead, priorities for the next reporting year include completion of the Fire Safety Management Audit, implementation of the enhanced HELM Fire Safety training package, progression of key capital fire safety projects, reduction of unwanted fire signals, ongoing management of high-risk register items, and the introduction of strengthened controls relating to lithium-ion battery risks across the Trust. Overall, the Trust remains committed to continuous improvement in fire safety compliance, assurance, and risk management.

4 Applicable Legislation & Guidance

4.1 **Regulatory Reform (Fire Safety) Order 2005:**

Commonly known as the Fire Safety Order (FSO); this is the core statutory framework for fire safety in England and Wales.

The FSO places duties on the 'Responsible Person'. usually the Trust CEO to:

- Conduct and record Fire Risk Assessments.
- Implement and maintain 'General Fire Precautions' (e.g. fire alarms, escape routes, staff training).
- Appoint competent individuals to manage Fire Safety.

4.2 **Fire Safety Act 2021 & Fire Safety (England) Regulations 2022:**

This extends the scope of the FSO to cover structural elements of buildings and external walls.

It has also Introduced additional obligations for "Responsible Persons" under Section 156 of the Building Safety Act 2022

4.3 **Fire Safety Guidance for Healthcare Premises (GOV.UK):**

Issued under Article 50 of the FSO to support healthcare-specific compliance.

The document details how to perform Fire Risk Assessments in Hospitals, Medical Centres and other Clinical environments.

4.4 **NHS Health Technical Memoranda (HTM) – the *Firecode* suite:**

The documents provide practical, healthcare-sector specific guidance for managing Fire Safety:

- HTM 05-01: Managing healthcare Fire Safety
- HTM 05-02: Guidance on functional design provisions
- HTM 05-03: Operational provisions (11 documents from Part A to Part M). This suite covers numerous aspects around Fire Safety including Fire Alarms, Training, Arson Prevention, Atria and Reducing False Alarms.

HTM 05-03 Part K: this document offers enhanced guidance on fire risk assessments in "complex" healthcare settings (e.g. Wards with immobile patients).

4.5 **NHS Trust Fire Safety Policies and Protocols:**

The Trust Fire Safety Policy is designed to reflect the FSO and HTM Guidance. The Policy covers a number of elements including Staff Roles and Responsibilities, Requirements for Fire Risk Assessments and a Training Needs Analysis Outline.

Fire Safety Protocols are in place to complement the Policy and provide direction and in-depth information on specific areas of risk (e.g. Arson).

4.6 **Supporting Frameworks & Standards:**

NHS SBS Fire Safety Framework: is the central procurement of, active & passive Fire Safety measures, and Consultancy Services.

British Standards: are the formal specifications and guidelines developed by the British Standards Institution (BSI) to ensure quality, safety, and consistency across products, services, and processes in the UK.

4.7 **Building Safety Act 2022 (BSA):**

The Building Safety Act 2022 (BSA) is a UK law, introduced following the Grenfell Tower fire of 2017. Its purpose is to improve the safety of buildings, strengthen accountability, and reform the building control system throughout a building's lifecycle.

For NHS trusts in England, compliance with the Building Safety Act 2022 (BSA) depends on whether they:

1. Own or manage existing higher-risk buildings (HRBs), and/or
2. Undertake construction or refurbishment works that fall within the Act's scope

UHL currently has three HRBs; these are the Balmoral, Windsor and Kensington Buildings at the LRI.

5 Roles & Responsibilities

Overall responsibility for Fire Safety will rest with the Trust Board. The Trust Board have overall accountability for the activities of the organisation.

The Chief Executive Officer (CEO) is responsible for ensuring that, through appropriate delegation of responsibility within the Organisation, current Fire Safety Legislation is met and that, where appropriate, Firecode guidance is implemented in all premises owned, operated or managed by University Hospital of Leicester NHS Trust (UHL).

The Director of Estates, Facilities & Sustainability holds the role of Nominated Executive Director Responsible for Fire.

The Trust currently employs three full time Fire Safety Specialist Officers and a Head of Fire Safety.

6 Fire Safety Policy & Protocols

The UHL Fire Safety Policy A7/2002 was updated in May 2025 and is due for renewal in May 2028.

The Fire Safety Team is currently in the process of developing a Fire Safety Working Group that will report into the Fire Safety Committee; once this takes place the Fire Safety Policy will require amendment.

There are currently four Fire Safety Protocols active and documented on the Policy; two further Protocols are awaiting approval by the Fire Safety Committee in May 2026.

Active Protocols

- Controlling Fuel Sources
- Arson
- Oxygen & Oxidisers
- Fire Stopping

Awaiting Approval

- Ignition Sources
- Fire Risk Assessment

Protocols in Development

- Fire Alarm Isolation Procedures
- Lithium Ion Batteries
- E-Bikes and E-Scooters
- Mobility Scooters

The Lithium Ion Battery Protocol was presented at the February 2026 Fire Committee meeting however; following new information, the document will receive changes prior to further consultation. It is also our intention to split the protocol into three elements (Lithium Ion Batteries; E-Bikes & E-Scooters; Mobility Scooters).

7 Fire Safety Committee (FSC)

Quarterly Meetings are carried out via Teams; this report is to be 'tabled' at the meeting on the 22nd July 2026.

The meetings for the next reporting year were planned to be held in May, August, November and February however; as the FSC reports into the H&S Committee, the decision has been made to move the FSC dates to times that allow for a better reporting process. The meetings following the planned May 2026 meeting will then

take place in July, October, January and April. The meetings will be on the 3rd Wednesday of those months.

Quarterly reports are produced and distributed amongst all relevant persons a minimum of five working days prior to the meeting dates.

An internal annual report is produced by the Fire Safety Team which is distributed to the Trust Board.

An external report will be carried out annually by a third party Authorising Engineer (AE Fire) and this will be shared with the Board to provide assurance with regards to the Trust Fire Safety Management compliance.

The appointment of DRLC as the AE (Fire) in March is a significant milestone and the initial annual audit is planned to take place on 28th May 2026; it is expected to receive the Draft report approximately four weeks from completion of the audit visit.

8 Enforcement & Fire Service Visits

8.1 Enforcement

On the 6th June 2025 the Trust received an Enforcement Notice from Cambridgeshire Fire & Rescue Service (CFRS), regarding the Peterborough Dialysis Unit; consequently the Unit was placed under a Restriction Notice. The notice was finally placed on the Trust following earlier issues with the building regulations submission. The restriction prevented the Unit from treating more than 10 patients in the large open treatment space.

Following six months of design alterations; elements of the building were altered to meet compliance with HTM 05-02 Guidance in support of functional provisions (Fire safety in the design of healthcare premises). The changes were mostly made around fire compartmentation along with a widening of parts of the external means of escape.

On 22nd December 2025, CFRS carried out a further inspection of the Unit; the Restriction Notice was lifted immediately and the Unit returned to providing treatment to the originally planned amount of patients.

8.2 Fire Service Visits

Leicestershire Fire & Rescue Service visit the Trust on regular occasions; they carryout periodic risk visits which involves a walk around individual buildings while inspecting services provided under B5 of Building Regulations Approved Document B; they also ensure that all information they hold about the buildings and incorporated risk is up to date and accurate.

In addition to Risk Visits, they carryout full audits of individual buildings in line with the FSO. Elements of the audit are directly linked to each Article identified under the FSO and breaches can result in Enforcement Notices being issued to the Trust.

8.2.1 Fire Service Audits

Ten Audits were carried out by LFRS & NFRS within the reporting period; the locations and dates of the Audits are listed below:

- 23rd June 2025 – Northampton Dialysis Unit.
- 23rd June 2025 – Kettering Dialysis Unit.
- 8th July 2025 – LRI Balmoral Building (Post Catering Fire)
- 7th October 2025 – LGH EMPCC Building.
- 7th October 2025 – LGH Catering.
- 7th October 2025 – LGH H Block.
- 7th October 2025 – LGH Zone 1.
- 7th October 2025 – LGH Zone 2.
- 7th October 2025 – LGH Zone 4.
- 11th December 2025 – LRI Windsor Building.

Nine of the audits provided an acceptable result of 'Broadly Compliant' however; the new EMPCC Building at LGH was subject to a deficiency Letter from LFRS. The letter identified issues with the cross corridor sub-dividing door sets. The issue involved excessive gaps that would prevent the spread of the products of combustion through them. This issue was identified by the Fire Safety Team during snagging prior to the Building opening. This issue is discussed further within Section 12.2 of this report.

A post fire audit relating to the 2024/25 Catering fire was carried out; no issues were identified and the result was deemed as Broadly Compliant.

The Trust had also prepared for Audits of the Sandringham and Clinical Genetics Buildings in December 2025 however; these were cancelled by LFRS and we are still awaiting new dates to be provided. It should be noted that LFRS are required to provide 28 days notice for the audits to be carried out routinely.

A post fire audit was planned for the 13th February (Balmoral Level 4 Fire) however; following information provided by the Fire Investigation Team and also from the results of the previous post fire audit on Balmoral (08/07/25), the audit was cancelled and deemed not necessary.

8.2.2 Fire Service Risk Visits

LFRS carried out five Risk Visits in Quarter Four however; they also carried out a Station Manager Familiarisation Visit.

- Risk Visit; 6th June 2025; LRI Sandringham Building.
- Risk Visit; 6th June 2025; LRI Emergency Department.
- Risk Visit; 10th October 2025; LRI Site Access.
- Risk Visit; 27th November 2025; LRI Windsor Building.
- Risk Visit 14th January 2026 – LRI – Windsor Building.
- Familiarisation Visit – 27th February 2026 – LRI – Whole Site.

9 Freedom of Information Requests

There was a single Freedom of Information Request in March 2026, where the Fire Safety Team was required to provide information.

The request was based around the Trust being required to use a 'Waking Watch' following fire alarm unserviceability; at the time of the request the Fire Safety Team was not aware of any recent occasion where a 'Waking Watch' had been required.

10 Fire Risk Assessments

10.1 Fire Risk Assessment (FRA) Programme

There is a requirement under Article 9 of the Regulatory Reform (Fire Safety) Order 2005, for the Responsible Person to ensure that all areas attaining to the Trust are provided with a suitable and sufficient Fire Risk Assessment.

The FRA is to be regularly reviewed and where it is suspected that the FRA is no longer valid a new FRA is to be completed.

The FRAs are split into two categories in line with HTM 05-03 Part K (Guidance on fire risk assessments in complex healthcare premises); Primary and Secondary:

- Primary – FRA relating to shared/ overarching general fire precautions, facilities, and the overall building management arrangements e.g. Full building including circulation spaces.
- Secondary – FRA relating to locally assessed and/or managed areas e.g. Single Wards/Departments.

The FRAs are to be reviewed in line with the Trust Fire Safety Policy; the frequency is self-imposed. The frequency of review is determined by risk and the outline is identified below however; it should be noted that the review dates can be brought forward if determined by the Fire Risk Assessor:

- Inpatient – Annually
- Outpatient – Every 2 years
- Administration – Every 3 years

10.2 Fire Risk Assessments/Reviews Completed

During the reporting year, 156 FRA/Reviews were carried out across all three acute sites and within Trust managed satellite sites.

Table 01 below identifies the inspections per site, per quarter; it also provides an annual total of FRA/Reviews carried out:

Table 01:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
LGH	8	7	6	4	25
GH	6	16	18	16	56

LRI	10	22	11	23	66
Satellite	6	2	1	0	9
Total	30	47	36	43	156

10.3 **Fire Risk Assessment Review Status**

Table 02 below identifies the amount of Fire Risk Assessment in place and also those due for Review at the completion of the reporting year:

Table: 02:

	FRA Completed	Review Due
LRI	165	17
LGH	95	26
GH	145	16
Satellite	19	2
Total	424	61

10.4 **Items of Note from FRA Action Plans**

Each FRA/Review generates a significant findings and action plan; from the beginning of Quarter Three 2025/6, selected issues from those action plans are being presented at the quarterly Fire Committee meeting. It is expected that the items presented will generate actions that are to be monitored through the Committee.

The issues identified through the FRAs will be supplemented by issues raised previously through Capital Projects and also issued raised through the Fire Safety Team by members of Staff.

A spreadsheet identifying the initial issues/observations raised is located within Appendix 'A' of this report.

11 Risk Register & Capital Risk Priority

11.1 **Risk Register**

On the 31st March 2026, there were 57 Fire Safety entries on the E&F Risk Register. Table 08 below identifies the risk rating breakdown of all Fire Safety issues:

Table 09:

	High	Medium	Low
E&F Risk Register Entries	31	24	2

Out of the 31 High Risks, three are scored as 20, a further one at 16 and the rest as 15; the three scored at 20 are listed below:

- The Glenfield fire alarm is aging and parts have become very difficult to access for repairs. We have been informed that a failure of specific parts could leave areas of the system unserviceable for extended periods. The information provided by the Third Party responsible for maintaining the system can be witnessed in Appendix 'C'; the information provided has led to this risk becoming the number one Fire Safety priority for the 2026/27 financial year.

- The Balmoral & Windsor Building fire compartmentation (2 x Risks) has been identified following reports of uncontrolled smoke spread during the Balmoral Catering fire. At present we are unable to appropriately inspect the fire compartmentation as we have limited fire strategy drawings that identify the building compartmentation lines. There is a three point plan to project that aims to rectify the issue:

    - Appoint an architect to draw up accurate fire strategy drawings.
    - Appoint a suitable third party to inspect all compartment and sub-compartment lines. Following the inspection, an itemised register of all breaches with a 'Risk Rating' is to be provided.
    - Capital Projects are to create a multi-year work programme for the rectification of all breaches.

During this reporting year we have transferred all but two of the risks on the 2023 tracker onto the 2024 tracker. The remaining two risks require expansion as they are moved and consequently we are waiting for information to be provided with how we can best split the risks down. It is expected that this will take place in Quarter One of the next reporting year.

11.2 **Capital Risk Priority**

The Fire Safety Team provides Capital Projects with a Priority List annually; all items on the list are documented on the E&F Risk Register. Table 10 below identifies the whole Priority List and its current position with regards to progress. Those risks highlighted in blue have been allocated funding or are currently being addressed.

Table 11 below identifies the new order of priorities provided to Capital Projects for the 2026/27 reporting year.

Following meetings with regards to Backlog Maintenance, it was decided to add 21 extra items to the Priority List currently in place with Capital Projects. These are indicated in the table as New Items and progress will be monitored through the Fire Safety Committee meetings. All items in green have been completed in this financial year.

Table 10:

2025/26 Priority List					
Site	Priority	Date	Value	Current Status	Comments
LRI	Evacuation Lift required for Kensington Building	25/26	£750k	Capital Projects	High Risk (15); In Process with completion due in July 26
LRI	Osborne Building requires new Fire Alarm	25/26	£350k	Priority List	High Risk (15); out to tender but subject to change due to GH fire alarm issues
GH	GH requires new Fire Alarm	25/26	Not set	Priority List	High Risk (20); placed top of priority list.
LGH	LGH Fire Alarm; Panel 117 upgrade/migration	25/26	£250k	Capital Projects	High Risk (15); In progress.
LGH	Graphics for fire alarm panels 111, 114 & 110	25/26	£10k	Capital Projects	High Risk (15); In progress.
GH	Above ceiling compartmentation work	25/26	Unknown	Capital Projects	High Risk (15); In progress and to be done over multiple years; Dean Jackson.
LGH	Maternity roof space requires additional exit	25/26	Not set	Priority List	Excessive travel distance for workmen in roof space
LGH	Substations 1,2 & 3 require detection installing	25/26	£25k	Capital Projects	On the new priority list
LRI	Compartmentation Breaches in Jarvis & Kensington Basement	25/26	£100k	Priority List	On priority list. Price quoted is 'High Level'.
LRI	Two escape staircases in staff multi-storey car park require opening.	25/26	Not set	Priority List	Was closed to prevent unwanted access. On priority list.
GH	The CDU requires sub-dividing to make compliant as the current compartment size is to large and there are to many patients in that compartment	25/26	Not set	Priority List	Doors have been removed during historic works. On priority list.
LRI	Both glazed escape staircases in Balmoral require new door sets provided on level 1.	25/26	Not set	Capital Projects	High Level Price is £20k; in process.
LRI	Cross corridor door sets in theatres (ones not previously changed during refurb works) are FD30S	25/26	N/A	Done	Completed

	and require replacement with new FD60S door sets				
LRI	Installation of graphic panels within the Windsor Building as per Balmoral and change to double knock	25/26	£20700	Priority List	Price provided by Ventec on request (Aug 2025)
Sat	Two new final exit door sets required for the Loughborough Dialysis Unit.	25/26	Approx £20K	Done	Completed (this was added at short noticed and completed asap due to immediate reactive requirement.
LRI LGH	The fryers in restaurant kitchens at LGH & LRI require fire suppression system	25/26	£50k	Done	Completed
Additions for 2026/27					
All	Lifts across all three sites are not linked to fire alarm cause and effect; strongly recommend that they are linked and access appropriate floors on fire alarm activation; this includes EMPCC	26/27	Not set	Priority List	202312FI25
GH	MRI (VIDA) has an extended travel distance as current exit does not allow for the safe escape of non-ambulant patients; new exit to be provided.	26/27	Not set	Priority List	202512FS26
LRI	Requirement for a new final exit being added to service level (Balmoral)	26/27	Not set	Priority List	202512FS24 Placed on the priority list.
LRI	Full survey of Emergency Lighting and Escape signage required of the Balmoral and Windsor service levels; this is linked to the issue raised regarding the requirement for a new exit from the service level.	26/27	Not set	Priority List	202512FS24
LRI	Replacement of Osborne automatic closers provided to Cross corridor and department fire doors; may require fire doors replacing at same time	26/27	Not set	Priority List	202312FI15 Door sets to be changed from double to single swing in order to prevent further issues. On priority List.

LRI	Full compartmentation survey of the Balmoral Building.	26/27	Not set	Capital Projects	202512FS28 In process
LRI	Full compartmentation survey of the Windsor Building.	26/27	Not set	Capital Projects	202512FS29 In process
LRI	Full compartmentation survey of the Kensington Building.	26/27	Not set	Capital Projects	202512FS30 In process
LRI	Full compartmentation survey of the Sandringham Building.	26/27	Not set	Priority List	202512FS32
LRI	Full compartmentation survey of the Osborne Building.	26/27	Not set	Capital Projects	202512FS31 In process
LRI	Full compartmentation survey of the Jarvis/RMO Building.	26/27	Not set	Priority List	202512FS33
All	Boiler House gas supplies not linked to fire alarms; require linking with auto 'shut off'	26/27	Not set	Priority List	202412FS07 On priority list
LGH	Fire Alarm - Migration of panel 116	26/27	Not set	Priority List	202506FS12
LGH	Fire Alarm - Migration of panel 115	26/27	Not set	Priority List	202506FS13
LGH	Fire Alarm - Migration of panel 125	26/27	Not set	Priority List	202506FS14
LGH	Fire Alarm - Migration of panel 111	26/27	Not set	Priority List	202506FS15
LGH	Fire Alarm - Migration of panel 113	26/27	Not set	Priority List	202506FS16
LGH	Fire Alarm - Migration of panel 122	26/27	Not set	Priority List	202506FS17
LGH	Fire Alarm - Migration of panel in Ward 23 (Gent)	26/27	Not set	Priority List	202506FS20
GH	Laboratory Wall in Pathology to be re-built (needlessly knocked down and not rectified)	26/27	Not set	Priority List	202509FS22
LRI	Potential conflict between ED Fire alarm cause and effect and the building lockdown for doors; recommend that it is fully inspected/tested to ensure both elements work correctly	26/27	Not set	New Item	202312FI33 Estates have identified the problem and also a potential 'fix'.

Table 11:

No	Priority	Comments
1	Glenfield Fire Alarm	Information required in how it can be done e.g as per LGH and broken down into zones/panels. Meeting planned for June 2026
2	LGH Fire Alarm	Continuation of panel by panel migration.
3	GH Compartmentation Works	Continuation of current works; next area is phase 1 ground floor.
4	LRI Osborne Fire Alarm Replacement	System is beyond its expected replacement or upgrade date.
5	LRI Service Level extra final exit requir	Extended travel distances due to obstructions. Fire Safety Team to carryout an initial risk assessment to identify full requirements.
6	LRI Service Level compartmentation	Survey previously carried out and issues need to be risk rated and made good as required.
7	Boiler House Gas supplies to be linked to fire alarms	LGH and Glenfield sites only.
8	Jarvis/Kensington Basement compartmentation.	To pick up following full compartmentation surveys arranged for the LRI.
9	CDU requires sub-dividing	To reduce numbers within sub compartments and match the current evacuation strategy for the area.
10	ED fire alarm and lockdown issues causing doors to lock	Estates investigating a fix at this time.
11	Lifts to be linked to fire alarms	Lifts are not linked to the fire alarms and need to be so that they respond appropriately in the event of fire.
12	LRI Osborne automatic door closers with circulation spaces to be replaced	Closers do not work as intended and doors do not close square on leading edges. Doors may require changing and change the opening to single swing from double swing.
13	Emergency lighting upgrade in service level	Current emergency lighting is not compliant
14	Windsor fire alarm upgrade to double knock and graphic panels added.	Priority is dependent on the DRAX system and whether it currently works or can be appropriately repaired if required.

Note: The tables above (10 & 11) do not contain the requirement for new Fire Strategy Drawings or for compartmentation surveys to take place across the LRI. These tasks were created following the fire in the LRI Catering Department in May 2025. The schemes are all linked to Risk Register items created following the fire and will be addressed by each site Capital Projects Lead. The schemes will be carried out as three separate tasks as identified below:

- New Fire Strategy Drawings to be developed; there is a minimum requirement of compartmentation lines on these drawings but each site will address accordingly and in line with available budgets.

- Fire compartmentation surveys to be carried out against the new strategy drawings. Due to the size of the task there may be a requirement to concentrate on all 60 minute fire resisting compartment lines first.
- Identified breaches of compartmentation to be made good in line with risks and available budgets; this is expected to be carried out through multiple year schemes.

12 Fire Training

12.1 Annual Fire Training (HELM)

The Trust aims for a compliance level of 95% and above; at the end of the reporting year, the Fire Safety Training was at 89%. It should be noted that this figure can change on a daily basis however; it has mostly been recorded between 88 and 91% throughout the reporting period.

Table 03 below identifies Annual Fire Training compliance for each CMG during the reporting period.

Table 03:

CMG	Q1	Q2	Q3	Q4
CHUGGS	93%	91%	91%	91%
CSI	94%	92%	93%	93%
Communications & Ext Relations	88%	64%	69%	80%
Corporate & Legal	73%	78%	78%	83%
Corporate Medical	90%	92%	94%	88%
Corporate Nursing	92%	87%	94%	95%
Emergency & Specialist Medicine	91%	90%	91%	89%
Estates and Facilities	90%	88%	91%	90%
Finance & Procurement	92%	87%	91%	90%
People Services	91%	89%	85%	88%
IM & T	83%	91%	94%	89%
ITAPS	96%	95%	95%	95%
MSK & Specialist Surgery	91%	90%	90%	91%
Operations	93%	92%	90%	92%
Reconfiguration Directorate	95%	84%	100%	100%
Research CRN EM	97%	99%	94%	94%
Research UHL	96%	92%	94%	100%
RRCV	93%	91%	92%	91%
Strategy Directorate	100%	92%	77%	89%
Women's & Children's	91%	88%	90%	89%

It should be noted that the figure of 89% takes into account the compliance figure for Bank Staff which was at 58% on the 31st March 2026; Bank Staff results are not provided within Table 03.

12.2 Standardised Fire Training (NHSE)

There has been discussions around standardised NHS Fire Safety Training for a number of years; the aim being to reduce the amount of training needed by Staff moving between Trusts. The Team have evaluated an e-learning session provided by NHSE and have attended two webinars regarding the potential changes.

Following a team assessment of the standardised training PowerPoint provided by NHSE, the decision to not use the session has been made; it is believed that the standardised training does not adequately provide sufficient information relevant to the specifics around the three UHL acute sites.

In order to guarantee that the current Fire Safety e-learning session provides sufficient information to ensure compliance with regards to HTM05-03 Part A; the Fire Safety Team has compiled a new e-learning session.

The aim was to have the new session active by the 1st April 2026 however; due to unexpected issues there has been a minor delay and it is scheduled to be active on HELM by no later than the 1st July 2026.

12.3 **Fire Evacuation Training**

A total of 66 'Table Top' Fire Evacuation Training sessions were carried out throughout the reporting year; training a total of 890 members of Staff.

Quarter 4 so the greatest number of sessions and persons trained, with 419 persons trained across 26 training sessions.

In Quarter One, a session was provided to 60 members of the LGH Theatres Staff. The group were provided with an initial collective theory session before splitting into three groups and running through differing fire related scenarios.

12.4 **Fire Warden Training**

44 Fire Warden Training sessions were carried out in the year, training 144 new Fire Wardens.

Fire Warden sessions often result in lower number per session due to the requirement and availability of Staff for the training.

Where possible the sessions are provided with or following table top evacuation sessions.

12.5 **Evacuation Aid Training**

Within Quarter One the team began purchasing new fire evacuation aids; the aim was to replace the old items with new and provide Staff with a more appropriate aid for the specific patient type.

Initially new Ski Slide Pads were procured to replace the AlbacMats. A full survey was carried out by the team with regards to the Departments that required evacuation aids to carryout safe vertical evacuation if required. Once purchased the relevant Estates Teams assisted greatly by providing Staff to locate brackets onto the walls for the aids to be mounted upon.

Once the new ski pads were in place, the Team purchased items for the Paediatric Departments; B Cots were identified as the 'ideal fit' following a previous exercise held within the Neonatal Department. During the exercise simulation it was noted that Staff struggled to carry the babies safely while negotiating lifesaving equipment. The B Cots are harnessed over the Staff members shoulders and allow patients to freely negotiate stairs while the baby is safely secured within the cot.

While replacing the two aids it was noted that there was a requirement in specific areas for evacuation chairs; these are provided through a case of need however; some Departments have purchased evacuation chairs through their own budgets.

The companies the items were purchased from, provided 'Train the Trainer' courses; as the Manual Handling Team were unable to attend the courses, the Fire Safety Team attended and now provide training with all items on request. This has taken up a significant amount of Team members time but provides a huge benefit that training can be carried out reactively.

Evacuation Aid training is split into three distinct groups:

- Ski Slide Pad
- Evacuation Chair
- B Cot Training

The Team currently provide user and train the trainer sessions for both the Ski Slide Pad and Evacuation Chairs.

Table 04:

	Q1	Q2	Q3	Q4	Total
Ski Slide Pad	N/A	93	74	24	191
Evacuation Chair	N/A	N/A	26	13	39
B Cot	N/A	N/A	0	0	0
Total	N/A	93	100	37	230

Table 04 above identifies the numbers trained since the evacuation aids were purchased. The numbers for this training are expected to drop as following the initial training, the training provided will mostly be for new Staff within the areas concerned.

A full list of persons trained, with dates and instructors is available from the Fire Safety Team on request.

12.6 Fire Evacuation Drills

The Team assisted with 5 fire evacuation drills over the year; the drills are listed below:

- Peterborough Dialysis Unit (Satellite).

- Loughborough Hospital (Satellite).
- Knighton Street Offices (LRI).
- BRU (Glenfield).
- Paget House (Satellite).

12.7 **Fire Extinguisher Training**

Fire Extinguisher Training will be provided in the next reporting year; a live fire training rig has been purchased and we are awaiting further items of equipment prior to arranging dates and locations.

The first use of the equipment is to be at the World Health and Safety Day at the Glenfield Hospital on 28th April 2026.

It is intended to train Fire Response Team members first, prior to holding open sessions across all three acute sites.

13 Unwanted Fire Signals (UwFS)

13.1 The Trust is required to monitor and reduce fire alarm false activations (Unwanted Fire Signals – UwFS); this is identified within both the FSO and HTM 05-03 Part B (Fire Detection & Alarm Systems).

Regulatory Reform (Fire Safety) Order 2005: Trusts, as "responsible persons," are legally obliged to ensure their fire safety systems are properly maintained and false activations are minimised.

13.2 **UwFS Occurrences**

Table 05 below identifies the amount of Unwanted Fire Signals that occurred in the reporting year at each site along with the amount of Fire Service Attendance (FSA).

Table 06 identifies the totals for the reporting period.

Table 05:

	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
Site	UwFS	FSA	UwFS	FSA	UwFS	FSA	UwFS	FSA
LRI	41	0	48	1	56	1	49	1
LGH	15	10	19	13	16	8	17	9
GH	14	7	9	8	12	11	13	7
Total	70	17	76	22	84	20	79	17

Table 06:

Site	Total UwFS	Total FSA
LRI	194	3
LGH	67	40
GH	48	33
TOTAL	309	76

This reporting year so a small rise in UwFS, with a total of 309 false alarms creating 76 Fire Service attendances.

The LRI had comfortably the most UwFS, with a total of 194 (63% of all false alarms) however; only 3 of these incidents resulted in Fire Service Attendance (4% of all attendances).

The LGH and Glenfield collectively had 115 UwFS but were responsible for 73 Fire Service attendances. Despite only providing 37% of false alarms the two sites are responsible for 96% of all Fire Service attendances.

The disparity in the figures is simply due to the investigation period in operation at the LRI; at this time it is not possible to operate the same way at LGH and GH due to the Fire Response Staff availability in an emergency.

13.3 **UwFS Causes**

Table 07 below identifies the causes of the Unwanted Fire Signals for the year:

Table: 07:

	LRI	LGH	GH	Total
Toaster/Cooking	13	5	8	26
Broken Call Point	98	5	3	106
Smoking/Vaping	7	0	1	8
Environmental	13	13	1	27
Fault in System	11	16	5	32
Alarm Testing	2	1	1	4
Contractors	6	2	4	12
Insufficient Information	44	25	25	94
Total	194	67	48	309

The largest cause is the accidental or malicious breaking of the manual call points. This accounts for 34% of all UwFS across all three acute sites and 51% of all UwFS at the LRI.

The 94 incidents with insufficient information to provide a reliable cause is a concern however; following a meeting in Quarter Three with the Switchboard Supervisors, the numbers have reduced by approximately 9 per month to 5 per month. On investigation of these occurrences it was noted that the majority of events without a cause were happening at either the LGH or Glenfield.

Out of the 309 UwFS, 63% of these occurred at the LRI however; only three resulted in LFRS attendance and is only 4% of all LFRS attendances throughout the year and 1.5% of all LRI incidents.

The low LFRS attendance at the LRI is purely down to the 5 minute investigation period in place. We have assessed the potential for introducing the same process at the other two sites however; there is insufficient Security Staff in place to guarantee the process would work appropriately. If we could use the same process at the LGH and Glenfield, it is estimated that we could have reduced the LFRS attendance to approximately 5 attendances across all three sites.

14 Capital Projects

14.1 The Fire Safety Team have provided Capital Projects with input on a significant number of schemes throughout the reporting year; a comprehensive list can be found below in Table 08:

Table 08:

LGH	LRI	GH	Satellite
LDC Extension	New UTC Building	Trust Med Pharmacy Extension	Skegness Dialysis Unit
New Endoscopy Building	Sandringham Pathology Scheme	Mortuary Refurbishment	Grantham Dialysis Unit
Pathology Scheme	Maternity Theatre Refurbishment	Pathology Scheme	Preston Lodge
Switch Room re-location	Windsor Extension	MRI Scanner Scheme	Hinckley CDC
Maternity Roof Improvement	Pharmacy Refurbishment		South Leicester Dialysis Unit
EMPCC Door Issues	Oliver & Rogers Ward Refurbishment		Kettering Dialysis Unit
	Replacement Escape Staircase for Jarvis Building		Peterborough Dialysis Unit
	Poppies Nursery Structural Issues		

An outline of the schemes with the most significant input is detailed within 12.2 to 12.9.

14.2 **LGH EMPCC Door Issues**

Observation:

Prior to completion of the new EMPCC Building, a number of issues were raised with regards to the fire resisting door sets; particularly the cross corridor door sets. There were excessive gaps clearly evident around double swing cross corridor door sets.

The issue was raised through Capital Projects, who raised the observation with the Principal Contractor. Once the building was occupied, fire risk assessments were carried out across all areas within the building (February 2025); the issues with the double swing cross corridor door sets remained and had not been addressed by the Principal Contractor.

The door issues were identified on the FRAs and directed to Capital Projects for rectification; once again the Principal Contractors were contacted.

On 8th October 2025, the EMPCC with provided with an audit under the FSO by LFRS; the double swing cross corridor door sets were raised as a concern by LFRS and subsequently the Trust received a Deficiency Letter from LFRS. The deficiency letter required us to rectify the excessive gaps at the top of the door sets; the issue was once again taken to the Principal Contractor.

Following an extended consultation with the Principal Contractor and fire door manufacturer; it was discovered that the door sets had been provided with elements of door furniture that were not part of its original testing; the installers had made a cost saving by using an inferior 'Shroud' that created excessive gaps that if subjected to appropriate testing, would fail and not meet the required standard.

We have been provided with an expected upgrade date on the door sets as May 2026; the manufacturer has confirmed that the new door furniture will rectify the issue however; door stops will be required at floor level. If the doors go past ninety degrees the door closer can damage the head of the door and consequently we have agreed to the door stop solution.

Lessons Learned:

The issue around the use of cross corridor double swing door sets has been a 'major stumbling block' around this project. The Fire Safety Team strongly recommend that the Trust no longer install double swing door sets; the team will instead identify a single direction of opening and the door leafs can then close into a rebated door frame.

Note: it should be noted that the same issue is evident within the new Endoscopy Building.

14.3 **LGH New Endoscopy Building**

Observation:

The original design of the new Endoscopy Building, provided to the Fire Safety Team was in line with HTM 05-02; Guidance in support of functional provisions (Fire safety in the design of healthcare premises). At a further meeting, the design had changed to that of an Approved Document B (Building Regulations) design; this change had been without consultation.

The change of design had allowed the Principal Designer and Contractor to reduce elements of the design as a cost saving factor. The main changes were:

- To identify the building as a single storey building by not identifying the first floor plant room as a dedicated storey.
- To identify all patients as ambulant by using Purpose Group 5 (Assembly and Recreation); this is the purpose group used for Health Centres.

Once the new information became available; the Fire Safety Team requested the walls and fire resisting doors were upgraded back to their original fire resisting standards (originally FR60 reduced to FR30); we stated that the Department would regularly treat Dependant Patients and that the Plant room should be identified as a first floor due to its internal staircase.

We were informed that our request would add 2 weeks onto the scheme completion and an extra £80k on the overall cost and it was not appropriate to make the changes requested; we accepted the Trust/Project position due to the risk to life around the change of design being low, however; we disagreed with the theory behind the decision to change the original design away from HTM 05-02.

Lessons Learned:

The Fire Safety Team should have been informed of the change of design document away from HTM 05-02. Fortunately the issue does not pose a risk to life however it does identify a lack of process and can lead to complications ‘down the line’.

What happened with the Endoscopy Building is very similar to the issues identified with the Peterborough Dialysis Unit; this building was subject to a change of Design Document without the Trust being informed and resulted in a Restriction Notice from CFRS.

14.4 **LRI New UTC Building**

Observation:

Following the start of the Project it was determined that there is a requirement for additional ‘Plant’ to be provided for the scheme but no location identified for its siting. A location has been identified but could provide an impact on the means of escape from the Service Level.

Lesson Learned:

At the beginning of each scheme, each design is often looked at in isolation; it would be prudent to have an ‘on-site’ meeting for all parties to understand any potential impact of the works on adjoining areas.

Observation:

This continues to be a difficult project to manage due to its proximity to the Balmoral Building main entrance and the fact that it is being adjoined to the Balmoral Building on both floor levels. Despite a number of complex issues, the Capital Project Managers have always kept the Fire Safety Team up to date with all aspects of the scheme and have created an excellent working relationship.

Lesson Learned:

The proactive stance and continual communication between Project Leads and Fire Safety Team has allowed potential issues to be averted prior to them occurring and allowed for a more compliant project to be in place from the outset.

14.5 **LRI Jarvis Building Replacement Escape Staircase**

Observation:

The current emergency escape staircase is not only in a poor state of repair, it is also non-compliant with regards to exit width and structurally; following surveys, the upgrading of the current staircase is not viable.

Consequently, a new staircase has been planned to be built in the same location as the current non-compliant one; unfortunately this causes issues as during the works period there will be no alternate escape route available and thus creating excessive single directions of escape in an emergency.

This causes issues on all floor levels however; the greatest complication is on Level 1 as this is a busy outpatient area; in order to adhere to single direction, distances of travel, a large area would require closing; this would have a significant impact on the operational effectiveness of the Department.

The Fire Safety Team has provided a solution that involves creating a new temporary corridor and thus providing a second direction of travel that removes any restriction.

Lesson Learned:

It is important that the guidance around travel distances is observed and followed as closely as is reasonably practicable. Where possible it would be prudent for all interested parties to discuss design collectively. This includes other interested parties than Fire Safety e.g. Security, Health & Safety, Estates Maintenance & Infection Prevention.

Observation:

Once a solution was identified by the Fire Safety Team, the Capital Projects Leads were quick to implement potential changes and identify the standards required in order to meet a compliant design.

Lesson Learned:

The diligence of the Project Lead to follow the advice provided by the Fire Safety Team, prevented confusion around the required solution and displayed an outward impression of a team working to one outcome.

14.6 **LRI Windsor Extension and Pharmacy Refurbishment**

Observation:

The Windsor extension has been under planning for approximately 6 years and within that time it has seen a number of Project Leads; the Fire Safety Team have been asked to provide consultation on the same issues throughout the planning stage.

Lesson Learned:

Providing the same information to differing Project Leads over six years has been frustrating and very time consuming. There appears to have not been a suitable handover between Project Leads and no progress folder kept by the Capital Projects Team. It should be stressed that this is not a reflection on individual project leads.

Observation:

The Windsor extension and the Pharmacy Refurbishment are closely linked but two separate Principal Designers has been used; this has led to confusion around the planning of escape routes between the two projects and also confusion around the boundaries of both projects.

Lesson Learned:

Ideally one Principal Designer would have been a better solution as it would have reduced confusion about how any works on one project may compromise the works on the adjoining project.

14.7 **Peterborough Dialysis Unit**

Observation:

The design of the building was changed from HTM 05-02 to Approved Document B without the knowledge of anyone connected to the Trust. This caused huge issues as the Approved Inspector used by Davita (Building owner/landlord) ignored the comments made by CFRS at the consultation stage; this led to CFRS providing the building/Trust with a Restriction notice.

Lesson Learned:

The Fire Safety Team had little input throughout the scheme and was not consulted around any changes to the design document; the first time the team were aware of any changes was when the pre-occupation FRA was carried out. It is important that the Fire Safety Team is informed of all relevant changes to design so that they can provide necessary comments.

It is strongly believed that if the Fire Safety Team had been informed that the design document had been changed; sufficient input would have been made to prevent the subsequent Restriction Notice.

14.8 **Hinckley CDC New Building**

Observation:

The Fire Safety Team were not informed of the use of the ground floor area at weekends and this created issues around the cause and effect of the fire alarm. The original cause and effect had an activation of the second floor plant fire detection, providing an alert (intermittent alarm) on the first floor and nothing on the ground floor. This works when all floors are occupied or fully unoccupied however; when only the ground floor is occupied it means they will not be made aware of a fire within the plant room.

Following discussions with NHSPS, the cause and effect has been changed and the ground floor now receives an alert signal (intermittent alarm) when there is an activation on any upper floor area.

Lesson Learned:

It is important that all information is requested and planned for during the early stages of the projects; this is made more difficult as the project was managed by an external third party and the building is managed by NHSPS.

Observation:

The escape drop down ladder from the roof is acceptable as a means of escape with regards to fire however; it is not of a type recommended by the UHL Security Team and poses a security risk.

Lesson Learned:

The Security Team were not engaged until the near completion of the project; at this time it was too late to make changes prior to occupation of the building. If they had been engaged at the design stage this issue would not have existed as a more appropriate escape ladder would have been installed.

Observation:

On completion of the building and during occupation it was discovered that NHSPS are stating that they have no responsibility for any maintenance around the buildings Switch and Hub rooms. This was clearly not identified during the planning or construction phase.

Lesson Learned:

This issue should have been addressed at the early contractual stages; is there a process used by the UHL Property Team to ensure that all aspects of building leases and Service Level Agreements are sufficient with regards to maintenance.

14.9 **Skegness & Grantham Dialysis Unit Works**

Observation:

The Skegness and Grantham Dialysis Units are not owned or Staffed by UHL however the patients are registered through the Trust. These buildings are undergoing either major refurbishment works or new build projects.

Due to the issues with the Peterborough Dialysis Unit, the Fire Safety Team has provided greater input around all satellite Dialysis Units however; this is not appropriate where UHL do not own and Staff the building.

Lesson Learned:

Where the building is owned and staffed by a third party (in the case of Skegness & Grantham it is Davita) the Fire Safety Team should be 'informed' and not 'informing'. If the team were to make comments or decisions that were to be incorrect or have a negative impact, the Trust would have no liability against it.

14.10 **Lessons Learned Overview**

When reviewing the lessons learned it is clear that the majority of issues are a result of incomplete/poor communication or a breakdown in the following of processes around project management.

In order to remove the risk of similar issues, we would recommend the following:

- Once the Fire Safety Team has provided comments, they should be informed of any changes involving design; this would prevent 'another Peterborough Dialysis Unit' occurring.
- It is important that all relevant teams are informed at the appropriate project stages; delaying interested parties input can cause non-compliance and avoidable excess spend on projects.
- Each project should have its own filing system with appropriate permissions for viewing/editing. This would have saved many hours of repeated work around the Windsor Extension Project.
- Each Project should not be looked at in isolation; the impact on adjoining Departments/Services must be taken into account.

15 Fires & Occurrences of Note

15.1 There were 11 Fires reported throughout the reporting period; brief outlines of each fire are provided below:

- 4th April 2025 – LRI Main Theatres – A therapy mattress was found to be on fire prior to an operation taking place. Staff noticed smoke emitting from what appeared to be a scorched area; the mattress was isolated and the fire extinguished with a foam extinguisher.

- 12th April 2025 – LRI Kinmonth Ward – A patients iPhone was accidentally knocked onto the floor by the cleaner; the lithium ion battery in the phone went into thermal runaway, emitting small flames and a significant amount of smoke. Patients were evacuated into the other half of the Ward as a precaution. No action taken with the phone as the combustion ceased however; the area was ventilated by opening windows.

- 10th May 2025 – LRI Catering Department – A blast chiller caught fire within the Catering Department; the fire escalated as the sandwich panels that formed part of the room construction began to delaminate and combust. The Fire Service attended the incident and eventually extinguished the fire.

- 13th Aug 25; GH; Ward 33; Microwave Fire. Cause of fire was Staff using a Regen Microwave as the Staff microwave was defective. The Regen Microwave is far more powerful and the items were placed in the oven for too long.

- 18th Aug 25; LRI; Materials Handling Ground Floor Store; PCB (Printed Circuit Board) Fire. Cause of fire was a loose connection which caused arcing across the unit and overheating.

- 20th Aug 25; LRI; ED Ambulance Assessment Area. Female Patient set fire to her bedding claiming she was bored; she extinguished it herself and the damage was discovered by clinical staff providing her with an examination. Damage restricted to small amount of bedding.

- 25th October - GH – CDU – Multiple Charging Adaptor
  The item was not purchased from procurement and began to get very hot and omit smoke; the issue was mentioned to the Fire Safety Team during a training session and following discussions, was removed from use.

- 6th November 2025; LGH; Ward 30; Microwave Contents Fire.
  A patient was using the microwave in the ward kitchen to sterilize feeding equipment. (Sterilizing bags). The microwave was left on for longer than the recommended manufacturer's instructions. This caused the bag to give off a large amount of black smoke. The kitchen door was closed and a "2222" call made. Smoke was restricted to the kitchen only. The Fire & Rescue service attended site. The microwave was removed by estates when cool.

- 29th Dec 2025; LRI; CICU; Staff heard a crackling noise from inside a store room. On investigation it appeared to be coming from a plug brought into the hospital by a patient to charge an electrical appliance. The issue was with the top pin being faulty and was pulling free from the plug when attempting to remove it from the extension lead. The noise heard by staff was electrical arcing.

- 22nd January 2026; LRI Balmoral Building, Level 4; Childrens Breakaway Room; Thermal Runaway on a Childrens tablet while charging. Significant damage to the room and minor smoke damage to adjoining rooms and circulation space. Fire Service provided full PDA and extinguished the fire. No patients were

moved/evacuated and no injuries resulted from the incident. A full report has been compiled by the Fire Safety Team.

- 15th February 2026; Glenfield Hospital; AHU 1 Supporting Ward 17; Electric Frost Coil Overheating. An issue arose with the units fan turning itself on and off; this caused the electric frost coil to heat the unit and not give the dampers chance to open, creating an oven like condition inside the unit. The junction box melted along with its contents; eventually the vision panel failed which allowed oxygen in and this caused the contents to 'flame out'. The fire burnt itself out as there was very little fuel available; no Fire Service attendance was requested or provided.

Reports of each fire are kept on file and are available from the Fire Safety Team on request.

Due to the severity of two of the fires, further information is provided

15.2 **Catering Fire**

The fire that occurred within the Balmoral Catering Department caused a significant amount of damage; a full investigation was carried out and a comprehensive report compiled. A brief outline of the fire is below:

- The day before the fire, a smell of burning was reported in and around the blast chiller. The chiller was checked by an engineer and isolated at the device as a point of safety.
- The fire occurred the following day and involved the blast chiller previously isolated; it was later discovered that the initial issue was with the 'incoming' electrical supply and not the chiller.
- The fire alarm operated as designed and a large Fire Service attendance took place; they were requested by the Duty Manager after the witnessing of smoke in the Catering area.
- The Fire Service investigation was protracted and complicated due to the unexpected movement of smoke to the Balmoral/Windsor Building upper floor escape lobbies.
- The fire eventually spread onto a food trolley which directly impacted on the 'sandwich panels' that the chiller room is partially constructed with.
- The sandwich panels 'de-laminated and the insulation within them melted and began to combust giving off large amounts of thick toxic smoke.
- The Fire Service eventually gained access to the room and extinguished the fire.
- There was a significant amount of smoke damage in the area and minor smoke damage in adjoining areas, including some upper level spaces.

Following the incident, the Capital Projects Team and Estates have made great efforts to address any evident failings around compartmentation that didn't prevent the transit of smoke.

The buildings are being provided with new Fire Strategy Drawings and following that; full compartmentation surveys will be carried out against them to identify any compartment breaches/failings. The final part of the scheme will be to make good

all breaches in line with their risk rating; prior to the works, the breaches will be risk rated and placed on the E&F Risk Register.

15.3 Balmoral Level 4 Fire

The fire occurred within a 'breakaway room' on Balmoral Level 4; the room is adjacent to the lift lobby and located between Wards 10 and 11. A patient had been in the room with parents and staff; at the time they had been using a Childrens electrical tablet purchased from a 'Wish List'. A full investigation was carried out and a brief outline of the incident is below:

- When leaving the room, the device was placed 'on charge' and left on a chair within the room; the door was then wedged/held open.
- It was eventually identified that the tablet was one of a collection purchased through Amazon off a 'Wish List'.
- The item was placed on a fast charge but this wasn't appropriate for this type of tablet.
- At some point the devices Lithium Ion battery went into 'Thermal Runaway' and began to combust; these temperatures can eventually reach in excess of 1000 degrees centigrade.
- The burning tablet ignited the chair it was placed on and the fire developed significantly.
- As the fire began, the smoke detector in the room had operated; staff from Ward 10 heard the alarm and investigated. On witnessing the fire, they removed the item holding the door open and made a '2222' call; the fire was too large for them to tackle with an extinguisher.
- On arrival the Fire Service gained entry and extinguished the fire; they then proceeded to ventilate the area with the aid of large fans.
- The room was badly damaged from the heat and smoke produced; smoke was able to enter the two adjoining storage areas, causing medical supplies to be deemed unfit for use and disposed of.

Despite the severity of the incident the actions of Staff within the local area and those attending in response to the fire, was exemplary. The response from Estates and Facilities Staff was particularly pleasing; Engineers, Porters and Domestic personnel, to name just a few, flooded the area once the Fire Service finished operations, in order to get the area back up and running and return to normality.

15.4 Incidents of Note:

There was a further incident that occurred that can be described as an incident of Note or Near Miss with regards to Fire:

- 22nd March 2026; LRI; ITU; Damaged Plug & Scorched Socket. The damage to the plug and socket was noticed by a member of Staff in a single patient room within the ITU. The patient was moved from the room as a precaution and Estates contacted. The item was removed (kettle) and the socket removed from use.

16 UHL Fire Safety in the Community

16.1 The fire safety team have continued to have a significant input into sites outside the main three Acute Hospitals; the majority of time being given to the Dialysis Units.

Preston Lodge was provided with a significant amount of input with regards to design and then following occupation, numerous training sessions. The training sessions were all based around fire evacuation, fire warden and evacuation aids.

This year so the completion and occupation of the new Hinckley CDC. Following completion of the building works the Fire Safety Team carried out an initial snagging visit prior to occupation; after occupation the building was provided with a new FRA and Staff trained in line with their new workplace.

16.2 **Non UHL Staffed Dialysis Units**

There are four dialysis units where the Trust have no Staff employed however; the patients are registered through UHL; the four units are listed below:

- Hamilton (Leicester)
- Boston
- Grantham
- Skegness

During the reporting period, Grantham and Skegness have been progressing through design phases for potential new units or large refurbishments.

Initially and as a result from the Peterborough Units issues around design, the Fire Safety team were being asked to provide advice/guidance. The team were happy to assist the building owners/landlords with the advice however; the Trust has no standing with regards to Fire Safety in the building and consequently no indemnity against any legal challenges. Davita have employed the use of a design company and Fire Engineers to provide fire consultancy with all design features.

16.3 **UHL Staffed Dialysis Units**

There are six UHL staffed dialysis units; the units are all provided with an FRA and they are reviewed every two years. Where requested Staff are provided with training and the team will also respond to reactive concerns. The six dialysis units are listed below:

- Leicester South
- Peterborough
- Northampton
- Kettering
- Loughborough
- Lincoln.

Fire Risk Assessments are in place for all sites and they have planned review dates of every 2 years.

Northampton and Kettering were audited by Northamptonshire Fire & Rescue this reporting year; both sites were identified as 'Broadly Compliant'.

Peterborough was placed under a Restriction Notice in June 2025 by CFRS; this was removed in December 2025.

Loughborough is located within Loughborough Hospital; this year was its first of being provided with a Fire Risk Assessment by UHL. Following the FRA; two final exit doors were replaced with new as a priority.

16.4 **Preston Lodge**

The team have provided significant input with regards to the design and fire safety provisions required of the building. The ground floor was initially refurbished and patients located within it. Almost immediately, work started on the first floor and the building is now fully open.

The Staff have been provided with a number of training sessions involving Fire Evacuation, Fire Warden and Evacuation Aids.

16.5 **Loughborough Hospital**

Loughborough Hospital was always risk assessed by LPT Fire Safety however; this year they changed their processes and it is now the responsibility of UHL to carry out all FRAs of areas under control of UHL. A list of the areas risk assessed by UHL is below:

- Outpatients 1
- Outpatients 2
- Surgical Day Case & Endoscopy
- X-Ray and Ultrasound
- Administration Offices
- Loughborough Dialysis Unit

16.6 **Hinckley CDC**

Hinckley CDC is a new build and located adjacent to the Hinckley Health Centre. The building is Staffed by UHL but the building is managed and owned by NHSPS. The team was involved heavily throughout the design/build phase and then in providing Evacuation and Fire Warden Training following occupation.

Further information regarding the scheme is identified within 12.8 of this report and concentrates on the fire alarm and installation of a vertical ladder from the roof.

17 Maintenance & Testing

17.1 There are a number of Passive and Active Fire Safety Measures that require periodic Maintenance and Testing. The Trust has a Duty under the Fire Safety Order to maintain these items and records are to be kept.

A list of the items requiring periodic inspecting/testing are listed below (this list is not exhaustive):

- Fire Resisting Door Sets
- Fire Alarm Systems
- Emergency Lighting
- Fire/Smoke Dampers
- Fire Suppression Systems
- Dry Risers
- External Escape Staircases
- Fire Extinguishers
- Hydrants
- Fire Shutters
- Fire/Smoke Curtains

17.2 E&F is currently creating a database that will capture all relevant testing and inspection information; the database is not complete and its Author due to leave the Trust within Quarter One of the next reporting year. We will request an update prior to the Author leaving and also from their replacement.

The Fire Safety Team has been provided access to the database for inspection and reporting purposes; Estates will be asked to report on compliance during the Quarterly Fire Committee Meetings.

The information provided will be captured within the Quarterly/Annual Reports as well as the external annual audit developed by the new AE (Fire).

18 Innovations & Future Work Plan

18.1 **What's New**

Several key initiatives have been progressed to strengthen fire safety governance, training, and operational efficiency across the Trust.

A significant development has been the appointment of DRLC as the Trust's Authorising Engineer (Fire) in line with the requirements of HTM 05-01. As part of this arrangement, DRLC will undertake an independent audit of the Trust's Fire Safety Management System during the first quarter of the next reporting year. The company currently undertakes the same role for Northampton Trust, providing additional assurance through its established NHS experience.

To enhance staff competence and engagement, the Fire Safety Team has invested in a live fire training rig, enabling more realistic and practical fire extinguisher training. The equipment is expected to be showcased at the Trust's World Health & Safety Day event, with a programme of extinguisher training to be rolled out initially for Fire Response Staff and Fire Wardens before wider access is offered across all hospital sites.

Progress has also continued on the P50 fire extinguisher replacement programme, a major innovation aimed at improving sustainability and reducing long-term

maintenance costs. Procurement activity is underway to secure competitive tenders, with implementation planned initially at Leicester General Hospital and Glenfield Hospital before extending to Leicester Royal Infirmary. The project represents a significant spend-to-save initiative, with projected savings expected to exceed those outlined in the Business Case due to the reduced impact of inflation on maintenance costs.

In support of continuous improvement and stronger governance arrangements, a new Fire Safety Working Group is being established. The group will report into the Fire Safety Committee and will provide a dedicated forum to address maintenance issues, prioritisation of fire safety risks, and the review and development of fire safety processes across the Trust. This will strengthen oversight, collaboration, and the timely delivery of fire safety improvements.

18.2 **2026/27 Work Plan**

The Fire Safety Team has identified the following strategic priorities:

- Complete independent Authorising Engineer (Fire) audit.
- Replace or migrate Glenfield Hospital fire alarm infrastructure.
- Continue LGH fire alarm replacement programme.
- Undertake major compartmentation surveys and remediation programmes.
- Improve fire training compliance towards 95%.
- Launch revised HELM fire training package.
- Introduce Fire Safety Working Group.
- Progress P50 extinguisher replacement programme.
- Strengthen management controls for lithium-ion batteries and personal mobility devices.
- Deliver priority capital fire safety projects across the estate

19 Appendix 'A'

Site & Date	Observation	Recommendation	Comments
All Dec 25	There are toasters purchased through procurement that do not 'pop up' on completion of the timers. This can and does lead to UwFS.	• Can procurement stop providing these items. • Staff education with regards to staying with the toaster when in use.	Originally observed in the LGH Delivery Suite. To be progressed via Fire Working Group.
All Dec 25	The greatest causes of UwFS are the accidental/malicious breaking of manual call points (MCPs).	Provision of covers to the devices as a deterrent.	Fire Safety Team are currently investigating costings. The aim would be to provide covers to high risk MCPs e.g. those adjacent to Ward main door sets. To be progressed via Fire Working Group.
All Apr 25	No cause of activation provided to Datix reports for UwFS.	Switchboard to ensure that causes are identified where possible.	Large improvement made in Q4; Team to continue monitoring.
All Dec 25	The team are unable to inspect above suspended ceilings during FRA visits due to the risk of Aspergillus.	There is a strong reliance on full compartmentation surveys and the following controls of those compartment and sub-compartment walls.	Compartmentation surveys have been added to the priority list. Strategy drawings to be completed in 2026/27 Q1 and compartment lines to

			be investigated on completion of drawings.
All Dec 25	There are limited fire strategy drawings available within the Trust; in order to carryout full compartmentation surveys we will require strategy drawings to inspect against.	Capital Projects have been provided with a request for strategy drawings; the request is aligned with the compartmentation surveys.	Meeting held on 29/4/26 with Chadwicks to identify compartment lines in Balmoral, Windsor, Kensington & Osborne. Chadwicks to complete strategy drawings.
All Dec 25	Charging of Tugs and other items within the corridors; this includes electric floor cleaners outside the domestic offices at the GH and mobile x-ray machines.	These items must not be charged in the means of escape at any times.	Still taking place; team have assessed adding of a compartment wall and door but this will only reduce risk (not as far as is reasonably practicable)
All Dec 25	Pallets being left in corridors following deliveries to Departments e.g. Glenfield Restaurant Corridor and LGH First Floor Corridor.	Once stock has been removed from the pallets, a job should be raised for the pallets to be removed to a safe external area.	On-going issue. To be progressed via Fire Working Group.
LRI Dec 25	Storage on the means of escape between ITU and Angiography that could delay or obstruct egress from the ITU.	All storage to be removed and the area monitored regularly to ensure the issue doesn't continuously repeat.	Identified on FRA Review under Local Management ownership. Kept clear in Apr 26 visit.
All Dec 25	Storage on the means of escapes across all three sites due to lack of storage facilities.	The means of escape to be kept free from all storage at all times.	Identified on FRA Reviews under Local Management ownership. Where the issue is difficult to resolve, metal cabinets are occasionally recommended as a managed solution.
All Dec 25	Magnetic door locks located on escape routes for some Wards meaning that the escape routes aren't being periodically inspected.	It is important that the escape routes beyond Ward door sets are inspected to ensure they are free from obstruction.	Identified on FRA Reviews under Local Management ownership.
All Dec 25	Corridors are often 'loaded' with beds and mattresses as the bed stores are already full; Medstrom also repair the beds within these corridors.	Beds and mattresses are not to be stored on the means of escape. Where U/S beds are removed from Wards for repair; this should be	Discussed at length and there is currently no contracted procedure to ensure that beds can be taken to a separate location for repair.

		done outside of the Hospital corridors.	
All Dec 25	Phone and tablet charging stations within the ward areas are often subject to sockets being overloaded through 'Daisy Chaining'.	It is recommended that charging takes place within hazard rooms. A one plug to one socket policy is to be adopted.	Identified on FRA Reviews under Local Management ownership.

20 Appendix 'B'

Proposed Business Case for Implementation of P50 Extinguishers

Case summary

The fire safety team are proposing replacing the 2 types of fire extinguishers (6 Ltr Foam & 2Kg CO2) we currently use for a single (6 Ltr Watermist) P50 extinguisher which is service free and doesn't require an annual or extended service(s) by an external contractor for the life of the extinguisher (10 Years)

Why make the change?

Conventional extinguishers require:

- To be annual serviced / inspected
- An extended service every 5 & 10 years
- If one is discharged this is a chargable event
- We will be subject to call out fees.

Versus: P50 Service free extinguishers

- Service free for 10 years
- No further services
- Free replacement with a FS Incident Number

- No call outs
- Reduced risks to staff potentially selecting the wrong type
- Eco friendly
- Consistency in line with Northampton & Kettering

Do the P50`s meet statutory compliance requirements?

Yes, they fulfil all legal and certification requirements.
They are CE marked, , and Kitemarked by the British Standards Institute (BSI) to BS EN3, ensuring that they are manufactured to the highest quality and performance standards. They are Approved by LPCB, accepted by the Fire Services and are used throughout the built enviroment.

The current fire safety legislation.

The Fire Safety Order requires compliance in two of the articles:

Art 13. Fire-fighting, and Art 18. Safety assistance (Competence), which states:

13.—(1)(b) Any non-automatic fire-fighting equipment so provided is easily accessible, simple to use and indicated by signs.

13. —(3)(b) Nominate competent persons to implement those measures and ensure that the number of such persons, their training and the equipment available to them are adequate, taking into account the size of, and the specific hazards involved in, the premises concerned.

18.—(1) The responsible person must, appoint one or more competent persons to assist him in undertaking the preventive and protective measures.

18. —(5) A person is to be regarded as competent for the purposes of this article where he has sufficient training and experience or knowledge and other qualities to enable him properly to assist in undertaking the preventive and protective measures.

Cost to UHL

There will be an initial financial commitment of £91.25+VAT per extinguisher for supply only and an additional cost for estates to fit brackets in areas where our existing brackets don't fit. The fire safety team will support training to the staff on how to use these along with providing a video on the fire safety connect page for viewers to use as and when they need / want.

The total one off financial commitment by UHL for the next ten years would be £136,875.00 + VAT. (£164,250.00)

A further saving will be realised should we decide to purchase the P50 again in 10 years as they give a 10% discount.

Statutory Compliance Requirement

In order to achieve compliance we would need to evidence the following:

The size and type of extinguisher to meet the identified risks / area

No-one would need to travel greater than 30mtrs to reach one

Routine inspections are carried out (monthly and annually) by a competent person (trained on site)

Financial Cost / Benefit Analysis

I requested information from our exisiting contractor (O heaps) for statements of invoices we paid between 2021 –2025 during that period we paid £156,884.96 (including Dry riser inspections), based on these figures over the next 5 years not inlcuding price increases we should expect to pay at least the same amount resulting in a ten year total of in excess of Circa £313,769.92. If we remove the estimarted price for the dry risers that will reduce the estimated overall cost to Circa £233,769.92. The overall investment cost of the P50 replacement is £136,875.00, this will realise a saving to the trust of approximately £96,894.92 over the period op the contract.

This would create a minimum of 41.45% saving over the next 10 years based on todays figures and doesn't **including any future price rises which would have a further increased saving from those suggested**.

Additional Benefit

Asset management toolkit to identify all loctations of extinguisher to ensure manditory complinace shcks and inspections are being carrie dout and recorded. Something we don't fully have now.

Scope of works detail

The detail for any further tendering process must include

Purchase of all extinguishers to meet the requirement BS3605.

Full installation, commissioning, signage and removal / disposal of existing units

Free training, and fire safety video evidence on how to carry out monthly checks.

Free speedy replacement for any faults where both gauges don't calibrate

Free speedy replacement for extinguisher used to tackle a real fire when provided with fire service incident number.

Free Computerised Extinguisher Management System

Proposed exchange schedule

Due to the financial commitment to be made it has been suggested that we spread the cost over several financial years, it is proposed that we initially replace the extinguishers at the LGH and GH first year and then LRI in a subsequent year. Reducing the commitment in any one year.

Existing numbers of extinguisher will be reduced by approximately 50%.

I would suggest we keep approximately 12 spares at each site so the figures quotes above include an additional 34 units as spares.

Leicester Royal Infirmary	1278
Leicester General Hospital	850
Glenfield Hospital	790
Paget House & Stable Block	14
Totals:	2932

Above are the figures provided by our current contractor; however there may be some discrepancies.

Proposal

Year 1: We replace the existing extinguishers at both Leicester General and Glenfield this will require:

Site	Number of P50 extinguisher needed
Leicester General	425
Glenfield Hospital	395
Total units in Year 1	820
Price per unit (lowest current quote) £91.25 +VAT	£74,825 + VAT = £89,790.00

Year 2: We replace the extinguishers at LRI, Paget house and Stable Blocks this will require:

Site	Number of P50 extinguisher needed
Leicester Royal Infirmary	639
Paget House & Stable Block	7
Total units in Year 2	646
Price per unit (lowest current quote) £91.25 +VAT	£58,947.50 + VAT = £70,737.00

Regards

Michael Lane AIFireE.
Fire Safety Specialist Officer
University Hospitals of Leicester NHS Trust
Estates and Facilities Building | Leicester General Hospital | Gwendolen Road | Leicester | LE5 4PW
Tel: 01162588060
Mob: 07483134220
Email: michael.lane@nhs.net

21 Appendix 'C'

Glenfield Hospital

Automatic Fire Detection And Alarm System

Delapidation Report

SYSTEM OVERVIEW

Glenfield Hospital is protected by a Signalco PBS 16 Analogue Addressable Fire Detection Network. The system was installed between 1996 and 1998
The overall system comprises of:-

- 22 No 8 Loop PBS 16 B2 Generation Control Panels
- Approx 6000 No Loop Devices
- Approx 160 Conventional Sounder Circuits
- 1 No Fire GFX Fire Alarm Graphics Server
- 7 No Fire GFX Remote Browsers at nurses Stations
- 1 No Fire GFX Remote Browser located at LRI Kensington Building Teleops

CAUSE AND EFFECT

The Site operates under a ‘Phased Evacuation’ philosophy. A SINGLE alarm activation within a Fire Zone will evacuate the Zone of alarm (Constant Sounders), and Alert all Adjacent Zones (Pulsing sounders). Plant will shutdown within the Zone of Alarm only.

CABLE INSTALLATION

The system was installed using Calflam Fire Rated Soft Skin Cable before the advent of Enhanced PH120 Fire Rated Cable. The RS422 Token Ring Network is installed in FP400 SWA Fire Rated Cable.

The Cable Installation remains in excellent condition. Earth Faults and Cable Faults are extremely rare, and generally only occur as a result of Water Ingress (Adverse weather and leaks) or incidents during construction/demolition. We would see no requirement for a full new installation driven by defective or degrading cable installation.

DETECTORS / SENSORS

The vast majority of detectors remain unchanged from the original installation in ‘97/’98. Faulty devices are replaced under normal Service and Maintenance operations. New and Refurbished areas of the site are fitted with new devices. But there remains a very high percentage of devices which have never undergone the recommended BS5839 10 year Service Renewal cycle. Devices are beginning to fail on a far more regular basis as the equipment age further. This is particularly prevalent with Ionisation type detectors.

CONTROL AND INDICATION EQUIPMENT

Wormald Signalco ceased trading and supporting the PBS range of equipment over 15 years ago. A Norwegian company bought the license to manufacture the product and set up a division under the brand name ‘Signalco Norway’. Made To Order replacement components are still available, however, supply is becoming more lengthy and expensive; and in our opinion should not be relied upon for a great deal longer.
A single Loop Card drives all 8 Loops in each panel. A failure of a Loop Card would result in a loss of 8 detection Loops.

Each Panel has a Token Ring Network Card which handles communication with the entire Network (and as such the Graphics Head End). Failure of a Network Card would result in a loss of Comms with the Network.

Each Panel also comprises of a Motherboard, a Front Card and any number of Sounder Control Cards (4 circuits per card). A failure of any of these circuit boards would impact protection in varying degrees.

The System's Operating Software, C&E Software and Text Information is contained within old processors and memory, which have a feasible life span of 10 years. These older components are difficult to source new, being 30+ year old technology. In the event that we are no longer able to source processors and Eeproms, it will not be possible to amend any future software should they fail.

COMPONENT AVAILABILITY

Detectors / Call Points / Interfaces / Sounders are all readily available, and present no supply issues. Control Panels and associated Circuit Boards are more of a concern. These have to be manufactured to order in Norway, and are becoming harder to source. Timescales and costs are also becoming an issue.

We do hold some Service Exchange stock for PBS16 B2, but again this is reclaimed from decommissioned systems and is also aging equipment.

CURRENT FAULTS

The system is currently in good order with minimal standing faults. One Panel regularly loses it's Initialisation Data but is still able to recover on Re-initialisation. The Network experiences intermittent comms issues, but again, these remain transient and not a permanent problem.

Generally, the engineers who work with the system at Glenfield regularly, report that the system is healthy, however it is without question becoming less stable as the hardware becomes older.

FUTURE CAPACITY

Each of the 172 Loops can accommodate 99 detectors and 99 Call Points & Interfaces. Many of the Loops are now full in terms of detector addresses (01 to 99). This is causing issues with C&E programming as we are having to bring loops in from other panels and other areas. Again, there is a cost implication against installation and commissioning.

SUMMARY

Our professional view is that the system is rapidly approaching End Of Life. The hardware is over 30 years old and is becoming less reliable. A full panel failure would prove very challenging to replace in a short time frame.

BS5839 recommends that devices are exchanged every 10 years, many of the devices at Glenfield are 30 years old.

We feel that a ‘Migration’ option of replacing Panels and Devices would be the most economical approach. This is supported by the fact that cabling and circuits remain in good condition. A Migrated upgrade could be delivered across an extended period to meet financial and budget constraints.

22 Appendix ‘D’

Sweco Building Control,
7200, Cambridge Research Park,
Cambridge,
CB25 9TL.

CAMBRIDGESHIRE FIRE & RESCUE SERVICE
Working together to improve community safety

For the attention of James Bosworth.

Our Reference: 297021 (please quote this number on all occasions)
File Number: 10093494596

Date: 20th May 2025.

Dear Sir.

FAILURE TO AGREE PROVISIONS.

BUILDING REGULATIONS 2010.
REGULATORY REFORM (FIRE SAFETY) ORDER 2005.
FIRE AND RESCUE SERVICES ACT 2004.
PREMISES: THE DIALYSIS UNIT, WESTWOOD FARM, BRETTON GATE, BRETTON, PETERBOROUGH.

BC REF NO: BC 66111591

I refer to the above Building Regulation application.

It is the view of Cambridgeshire and Peterborough Fire & Rescue Authority (hereafter "The Authority") that the proposed submitted consultation does not achieve an acceptable standard to satisfy the requirements of Part B, Schedule 1 of the Building Regulations 2010.

The application has been examined and my Fire Safety Inspector has responded formally stating our areas of concern. The Authority have stated in our response that we consider the proposal unsatisfactory within the following areas: -

1.1 It is noted that Approved Document B, Volume 2 has been used as the guidance document for this project. The Fire Authority disagree with the use of this document as it is not suitable for the patient dependency. HTM 05-02: Firecode, Section 2.19 states that dependant patients are all patients except independent or very high dependency.

The Fire Authority believes the patients to be dependent patients as per the supplied Davita Fire Policy, ref RS-033 and, therefore, HTM suite of documents should be used to achieve the functional requirements of the Building Regulations 2010.

1.2 HTM 05-02: Firecode, Clause 3.24 states that there should be a balance of patients between sub-compartments. The proposals are for 40 patients in the large compartment and 10 patients in the smaller sub-compartment.

1.3 HTM 05-02: Firecode, clause 3.25 (b) states that a compartment should be sub-divided if it contains departments to which more than 30 patients will have access to at the same time.

This Authority has set out its concern and recommendations in line with the Building Regulations 2010 and Regulatory Reform (Fire Safety) Order 2005 'The Order'.

It is a general duty under 'The Order' Article 8 (1) (a)(b) to ensure as far as reasonably practicable the safety of his employees & where relevant persons are not his employees, to ensure that the premises are safe. The following requirement **must** be complied with 'The Order' article 14 (2)(b) , 'that all relevant persons can be evacuated from the premises as quickly and safely as possible'.

It is the opinion of the FA that for a small premises with independent occupants a full evacuation of the premises can be achieved in 2.5 minutes. If on occupation it cannot be demonstrated to the FA that suitable procedures for serious and imminent danger have not been established and the safety of relevant persons cannot be evidenced, then formal action including the prohibition or restriction of the premises will be considered.

The applicant and the insurers should be made aware of the content of this letter.

The applicant will be required to address this within their Fire Risk Assessment before the occupancy of the premises.

You are advised that all comments are made in respect of the plans/information submitted through consultation BC 66111591. Cambridgeshire & Peterborough Fire Authority should be notified of any change or amendments to the proposals in order to ensure compliance with the above.

I enclose a copy of this letter and the appendix for the applicant and would be grateful if you would be kind enough to forward this to them.

Should you have any queries relating to this correspondence, or if this Service can be of any further help or assistance, please do not hesitate to contact Gary Doughty by telephoning 07771 993413 or emailing gary.doughty@cambsfire.gov.uk

Yours faithfully,

Gary Doughty.

for and on behalf of:
M WARREN.
CHIEF FIRE OFFICER.

Copy to applicant.

23 Appendix 'E'

University Hospitals of Leicester NHS
NHS Trust

Fact finding Review Report into the Peterborough Dialysis Unit

1. Purpose

The purpose of this report is to provide a structured review of the events and decisions that contributed to the unsuccessful opening of the Peterborough Dialysis Unit, as outlined in the terms of reference. The review seeks to clarify what happened, examine contributing factors, and draw out actionable lessons to inform and improve future projects at UHL. It is not intended to attribute individual blame, but rather to ensure learning and improvement.

2. Deliverables

The terms of reference (see Appendix 1) for this review were confirmed as signed off by Julie Lankester, Deputy Head of Operations (Chair) of the Peterborough Dialysis Unit Overview Committee, upon review by the committee on 4th of February 2026.

The report will focus on the following three areas:

- Fact-finding statement: a concise document summarising verified facts leading to the failure and lessons learned with recommendations for future projects.
- Supporting documentation: collated stakeholder submissions, reviewed documents, and interview notes.
- Suggested lessons learnt for future processes.

3. Methodology

All stakeholders were e-mailed by Vicki Turner on the 6th of February with a questionnaire as per the terms of reference, with a response date of the 20th of February. All responses were received by the 27th of February 2026. These responses can be found within the supporting documentation section of this report.

4. Background

In September 2023, DaVita was awarded the tender to deliver a new dialysis unit in Peterborough. The unit was delivered as a design and build project, with DaVita responsible for the building and UHL responsible for service delivery. DaVita relied on a main contractor to manage and coordinate all aspects of the design, construction, and compliance workstreams.

The specification issued by UHL required the facility to accommodate all current patients and anticipate further growth over the ten-year contract period. The unit opened with 35 stations fully equipped with no isolation rooms, alongside space allocated for future expansion of up to 48 stations (and capacity for 50 patients). On 5th April 2025, both the Mistry unit and the old Peterborough unit were closed, and the new Peterborough Dialysis Unit at Westwood Farm Industrial estate commenced operations on 7th April 2025.

There were several delays to the timeline which included the discovery of a borehole at the site; challenges with site access following the landlord's request for a new road, planning permission complications, including a failure to communicate a required planning notice by

Peterborough City Council, delays in BT installation; ongoing discussions regarding ventilation; and concerns relating to water quality. Collectively, these issues contributed to a shift in the overall project timeline, delaying completion. While these factors are acknowledged as contributing to delays in the unit's opening, they are not the primary focus of this report.

This investigation focuses on the fire restrictions placed by Cambridgeshire Fire and Rescue Service "CFRS" on the new unit at Westwood Farm Industrial Estate, post opening. Specifically, these restrictions which were imposed on 6th of June 2025 resulted in a reduction in the unit's capacity from 35 stations to 20 stations. The timing of this notice i.e. Friday pm posed significant operational and clinical risk and following a discussion with CFRS it was agreed that mitigations i.e. additional staffing and UHL paying for a fire appliance to be present at the unit on Monday 9th of June 2025 would delay the restrictions, with the capacity constraints being operational from 2300hrs on Monday 9th of June 2025.

The operational team put in several mitigating actions, including on the 11th of June reopening the Mistry unit. Further remedial work took place at Westwood Farm Industrial Estate, meaning that the unit was then able to open at its intended capacity i.e. the 35 stations on the 23rd of December 25.

The investigation explores what led to these restrictions being put in place and lessons that can be learnt for the future.

5. Summary of the impact of restrictions

Whilst the impact of the restrictions is not the primary focus of this report, it should be noted that there was a significant consequence. The following paragraphs summarise responses received through stakeholder questionnaires.

The restrictions had a significant impact on patients, including increased clinical risk due to reduced dialysis treatment times (from 4 hours to 3.5 hours), with associated risks of short-term complications and potential long-term morbidity and mortality. There was also an increased risk of non-attendance due to frequent changes in schedules, locations, and transport arrangements.

Patients experienced major disruption to daily life, including impacts on work, childcare, and social support. Treatment regimens changed on three occasions within a short period, with 20 patients moved to evening shifts, including some previously assessed as unsuitable due to frailty, age, or caring responsibilities. Some patients were required to travel to Boston or start dialysis as inpatients before transferring while awaiting a Peterborough slot.

Transport disruption led to delays, extended journey times, and in some cases missed meals, carers' support, or insulin administration. Treatment sessions were also occasionally shortened or delayed due to staffing pressures across multiple sites. There was a negative impact on patients' emotional wellbeing, trust in UHL, and reduced access to home dialysis training and respite care.

Staff experienced significant operational pressure, including frequent short-notice rota changes, inability to maintain flexible working arrangements, and challenges delivering home training. Covering multiple clinical areas resulted in short staffing, reduced senior support, longer working hours, and impacts on staff wellbeing. Ongoing building works and changing timescales also created uncertainty.

At an organisational level, the restrictions increased inpatient length of stay at Glenfield Hospital and Peterborough City Hospital while patients awaited dialysis slots. There was also an adverse impact on UHL's reputation and pressure on both the Renal Service Project Team and the UHL Fire Safety Team.

6. MAIN REPORT

6.1. Summary

The service specification issued by UHL intended that the facility comply with HTM 05-02 Fire code, reflecting the dependency and limited mobility of patients during evacuation, in the event of a fire. What is clear from this review is that the interpretation of HTM 05 requirements was an area where expectations were not fully aligned across all stakeholders through the project.

During the design phase the design code was changed by SWECO (the company sub-contracted by Davita) from HTM 05-02 to Approved Document B (ADB), based on the assumption that patients could be treated as independent, like those in outpatient or GP settings. The submission to building control by SWECO was on this basis. Throughout 2024 and early 2025, Cambridgeshire Fire & Rescue Service (CFRS) raised repeated concerns during the consultation process, particularly regarding the absence of a fire strategy, the proposed evacuation approach, compartment sizes, and the misclassification of patient dependency. Initial correspondence in July 2024 highlighted the lack of key fire safety information, and further submissions in January 2025 confirmed a design that CFRS considered non-compliant with HTM guidance. With correspondence in response from SWECO confirming that ADB had been applied, and their opinion was that this made the building compliant. There was a clear differing of views at this point.

Despite these concerns, the project progressed to build, without any change in design and the building became operational in April 2025. CFRS formally challenged the approach and issued a "Failure to Agree" letter on 20 May 2025, warning that enforcement action could follow if compliance could not be demonstrated.

A full evacuation drill conducted on the 3rd June 2025 demonstrated that evacuation would take approximately 12 minutes, significantly exceeding the 2.5-minute benchmark required under ADB for independent occupants. As a result, on the 4th June 2025, CFRS issued a Prohibition Notice restricting the occupancy of the unit to 20 patients, with agreement this led to a reduction in capacity at the unit from the 6 June at 2300hours and until the issues were resolved on 23rd of December 2025 when full capacity was restored.

The ability to open the unit fully and have the fire restriction lifted was delayed from the initial expectations whilst DaVita found a new company to work with. The initial design for the wall to separate the main clinical area into two compartments to meet HTM 05-02 requirements was not progressed as quickly as planned, as it was clear this would involve cutting into the renal water supply and the ventilation, a further design was submitted, but this had the same issue, causing further delays. Once the design was agreed work progressed promptly and the fire service lifted the fire restriction on 22 December 2025, the unit opened to all patients dialysing in the Mistry unit on 23rd of December 2025. Building work in the office areas continued after this date.

6.2. Assessment of the Root Cause

The fundamental issue that caused the unit to have a reduced capacity was the inappropriate application of design standards, specifically the decision to apply Approved Document B instead of HTM 05-02. HTM 05-02 is the correct standard for healthcare premises where patients are dependent or require assistance to evacuate, and it supports a progressive horizontal evacuation (PHE) strategy in a fire. In contrast, ADB assumes occupants are independent and able to evacuate simultaneously within a short timeframe, typically around 2–3 minutes.

To not follow the guidance within the HTM suite resulted in the main compartment housing more than 30 patients; full simultaneous evacuation was being proposed and there was an imbalance of patient numbers between the two original compartments, with 40 in the main compartment and 10 in the isolation ward. Once it had been decided that the guidance to be used was ADB Vol 2, there were issues raised by CFRS regarding patient dependency (being described as fully independent) and the ability of the end user (UHL) to manage and perform effective evacuation of all occupants in a safe and timely manner.

The classification of dialysis patients as independent was incorrect, as patients are connected to machines during treatment, may be clinically unstable, and often require assistance or transport via beds or chairs. The assessment or change to the dependency of patients should have been reviewed and agreed with the UHL team however this appears to have been undertaken by SWECO in isolation. The service specification clearly delineates that patients are dependent.

This misclassification led directly to a design that could not support safe evacuation. The strategy relied on full simultaneous evacuation, which was not achievable in practice. This change in design approach had significant consequences. The building layout, compartmentation, and exit provision were not adequate to support the safe evacuation of dependent patients.

Following enforcement action, the required resolution involved substantial redesign works to bring the building back into alignment with HTM principles. The design was to be altered to an HTM compliant design. This involved the adding of fire compartmentation and an extra final exit (due to changes of compartmentation). The external escape routes were also widened.

6.3. Context

From the stakeholder feedback this issue appears to have highlighted a broader concern. Stakeholders have referenced there to be differing interpretations of HTM guidance across organisations, with private providers, many NHS Trusts, and some fire services assuming that dialysis patients can be treated as outpatients who are able to self-evacuate. On that basis, an Approved Document B (ADB) approach has often been considered acceptable. This is in contrast, to the UHL renal nursing team's expectation which has always been that patients should be evacuated on beds or chairs. This aligns with the understanding of Cambridgeshire Fire and Rescue Service and the UHL fire officer responsible for the fire risk assessment.

CFRS confirmed that they have sort external assurance to validate the approach taken here this included.

- Essex Fire and Rescue Service conducted a peer review and confirmed agreement with the position.
- The National Fire Chiefs Council was consulted and supported this view,

- Fire service barrister David Stotesbury.

Although the UHL current specifications references HTM05-02, stakeholders have been clear that many previous units were designed in line with ADB principles. This discrepancy had not been identified during earlier unit developments or within prior fire risk assessments. These units are not subject to this review but provide context to how the differing viewpoints of stakeholders could have occurred.

The UHL renal team because of the learning has escalated the issue nationally for awareness. As a result, there is now recognition of the need for clearer, more consistent guidance for renal teams developing new facilities. UHL, alongside Birmingham, is supporting this work, reflecting the greater experience both organisations have due to the number of dialysis units they operate.

6.4. Communication

Concerns about the design were first raised as early as July 2024, when CFRS requested further information from SWECO due to the absence of a fire strategy in the initial submission. Further issues were identified in January 2025 when revised drawings were submitted, at which point CFRS explicitly challenged the non-compliance with HTM guidance and the inappropriate use of ADB. Correspondence continued through late January and early February 2025, with CFRS clearly stating that the proposed design did not meet regulatory requirements due to incorrect assumptions about patient dependency. Despite this, the design team (SWECO) maintained their position, and no resolution was reached. A formal escalation occurred on 20 May 2025, when CFRS issued a "Failure to Agree" letter outlining their concerns and the potential for enforcement action.

Despite the plethora of communication on the concerns relating to this matter, the issue was not fully recognised operationally prior to the building opening in April 2025, and key stakeholders, including the UHL renal team, only became fully aware of the severity of the risk following the CFRS site visit. The issue was definitively confirmed during the evacuation drill on 3rd June 2025, which demonstrated that the required evacuation times could not be achieved. This led directly to the Prohibition Notice issued on 4 June 2025. In summary, while the risk was identified during the design and consultation stages, it was not effectively resolved or acted upon until after the building was operational and enforcement action had been taken.

What is clear is that the UHL team were not cited to the views of CFRS until the failure to agree notice on the 20 May 2025 was issued to CFRS and received by the UHL team on the 28th May 2025. There is no evidence that the correspondence between CFRS and SWECO dating back to July 2024 was shared with the UHL team (clinical, operational, fire or estates). DaVita were also clear as a stakeholder that they were not aware of the magnitude of the issues until the notice was received. They had believed that previous concerns from CFRS had been addressed.

6.5. Compliance Assurance

Whilst it is clear that the UHL team were not cited to the views of CFRS until post the opening of the building, what is not so clear is if the UHL team had been cited to the change in design code, but had not understood the implications at an earlier point. For example, were designs draft to ADB signed off by the project group, as the project moved to build based on those designs, one would infer they were. That aside there does not appear to be any formal

agreement to explicitly move from HTM to ADB designs or agree any derogation to the service specification, which references HTM compliance and the dependency of patients.

It is also clear that there does appear at the time there was a lack of understanding by the UHL operational team of the difference between ADB and HTM within the design phase of the project, until this was later raised as part of the CFRS concerns when the matter was fully understood alongside the implications.

6.6. UHL Fire Team involvement

Some stakeholders have identified the earlier involvement of the UHL Fire Safety Team as a key lesson learned. While early engagement is important, the evidence indicates that the UHL Fire Team was, in fact involved at an early stage of the project and had already identified critical concerns during the design phase.

Specifically, the UHL Fire Safety Team raised the absence of a fire strategy document as early as November 2023. This issue was also later reflected in feedback from Cambridgeshire Fire and Rescue Service (CFRS), who similarly identified that the lack of a fire strategy document, this prevented both parties from providing fully informed advice at an early stage.

A fire strategy document, is typically produced by the Principal Designer, is a fundamental element of fire safety design and should include:

- The applicable building design code (e.g. HTM 05:02 or Approved Document B)
- Compartmentation details
- The evacuation strategy
- Fire separation distances from adjacent buildings
- Fire detection and alarm systems

Despite multiple requests from the UHL Fire Team, no fire strategy document was provided during the design stage. This omission, combined with changes in the adopted design standards and differing assumptions between SWECO and UHL regarding patient dependency, significantly limited the ability of the UHL Fire Team to provide meaningful early input.

An online meeting was held on 09 October 2024, prior to which a fire strategy drawing was provided but no strategy document. At no point was a complete fire strategy document issued to the UHL Fire Safety Team in the design phase. Further evidence of process confusion was identified in correspondence dated 20 November 2024, when the UHL Fire Team received a request from the UHL Renal Project manager asking them to provide the fire strategy document to DaVita. It was clarified in their response that responsibility for producing the fire strategy document and associated drawings lies with the project's design team (i.e. the Architects/Principal Designer), not UHL. This highlights a lack of clarity regarding roles and responsibilities among project stakeholders but also a lack of understanding of the importance of this missing document.

Typically, the fire strategy document is submitted to Building Control alongside supporting drawings, who then consult with the relevant Fire Authority in this case, Cambridgeshire Fire and Rescue Service (CFRS). As such, the absence of this document also represents a breakdown in expected design and approval processes.

On 25 March 2025, a UHL Fire Safety Officer raised concerns that the building was compliant with Approved Document B (ADB). However, no further action was taken by the UHL project team at that time, as the implications of this compliance particularly in relation to patient dependency and evacuation assumptions appear to not have been fully understood. On the 7th May 2025 a Fire Risk Assessment "FRA" at the site was carried out at the site by the UHL fire team, the site was now occupied by staff. The FRA raised several concerns, mostly with the fire evacuation strategy due to the building appearing to have been constructed in line with Approved Document 'B' instead of HTM 05-02. At this point it was confirmed CFRS had raised similar concerns and the UHL fire team contacted CFRS on the 29th May 2025.

It appears that there was a missed opportunity on the 25 of March to take some action. Whilst this was late on in the process this feels like a key point that the issue could have been picked up prior to opening, with action taken proactively rather than reactively.

7. OPPORTUNITIES FOR LEARNING AND RECOMENDATIONS

It should be noted that the UHL team are one of the most experienced and effective at commissioning renal units of this type in England and influencing nationally the direction of travel and learning in this space. It is evident from the feedback I have received that significant reflection and learning since the events have already taken place. Therefore, these following paragraphs include learning that the stakeholders have already identified.

7.1. Project Management

The existing project manager sits within the Renal Services team, with operational experience. Clearly this expertise and oversight is needed in a project of this magnitude however feedback from technical stakeholders is that it would be advisable to also have an allocated Estates and Facilities Capital project manager, to work in conjunction with them. This could have meant that there was a better understanding of the implications of there being no fire strategy document present in the design phase, ensured that they were cited to feedback from the building control process and also the implications of the HTM design not being utilised. It would also be beneficial for all project documentation to be stored in a central depositary with gateway checks to ensure that key documents are received and approved at the design phase prior to moving through to build.

7.2. Service Specification

The project highlighted a need to strengthen service specifications. It is essential that building owners and landlords fully understand their obligation to deliver facilities that comply with NHS standards, including Health Technical Memoranda (HTMs) and Health Building Notes (HBNs), rather than relying on general commercial building standards. While HTM requirements were referenced, within the service specification, this was largely limited to the maintenance phase and did not sufficiently address the design stage. For example, the service specification details the requirement that the unit complies with HTM's in general. No reference to HTM 05:02 'Fire safety design' was referenced, but HTM 05:01 'Managing healthcare fire safety' was mentioned in reference to maintenance only and not design.

It is essential that patient dependency is properly understood and explicitly incorporated into design and fire evacuation strategies. Dialysis patients, for example, should be considered dependent on staff for evacuation, which has significant implications for compliance with HTM guidance. Failure to correctly classify patient dependency can lead to inappropriate design

assumptions, particularly where standards such as Approved Document B are applied instead of healthcare-specific guidance. The service specification does reference the level of patient dependency, but it could go further in terms of relaying this in the context of the (HTMs) and fire evacuation strategies and for this reason it is advised this is strengthen in future specifications.

Future service specifications should explicitly incorporate design requirements, ensuring alignment with UHL Capital Projects templates. This should cover the full scope of Hard and Soft Facilities Management, including space planning.

See also Indemnity and responsibility clarity for recommended amendments to the service specification.

The service identified that there is work nationally on the development of a national service specification for Renal Dialysis Units being procured in this way, however in the absence of this being in place, the above amendments to the existing specification are recommended.

7.3. Indemnity and Responsibility Clarity

There was consistent concern from technical stakeholders at UHL that UHL staff should not be utilised as unpaid external consultancy for third-party developments. Responsibility for specialist design disciplines, including fire engineering, ventilation, and water systems must rest with the provider's appointed consultants with the specific concern that UHL could inadvertently assume design responsibility or liability for property that sits with the landlord and their design team.

In light of the above it was highlighted that the level of UHL engagement should be clearly defined and quantified within service specifications to ensure appropriate boundaries are maintained. UHL should explicitly set out the expected level of technical input, consultation, and expertise to be provided by external providers, making clear that these responsibilities sit with the appointed contractor or organisation responding to the tender, rather than relying on input from UHL. This approach will support UHL in maintaining its role as an informed client and help prevent it from assuming responsibility for design or specialist technical assurance. This approach would be supported by the recommendation to have a UHL capital project manager allocated to future projects.

DaVita identified, as part of their project learning, that their future schemes will include the appointment of an independent Authorising Engineer from the design stage through to handover. This role would provide ongoing assurance of compliance and support the early identification and mitigation of risks. Whilst this is helpful for the project management it will also help support the concerns around external consultancy listed above it. Consideration should be given to whether it is appropriate to include this requirement into the service specifications to ensure this is in place within future projects which may not include working with DaVita.

7.4. Coordination, Communication, and Compliance Assurance

There were clear gaps identified in the coordination between the design, construction, commissioning, and handover phases. In this case, key design issues were not identified early enough, and once construction had progressed, the ability to achieve compliance became significantly constrained without major reconfiguration. This highlights the need for more robust design assurance and earlier technical review.

There are also important lessons regarding communication and transparency. The change from an HTM-based design approach to one aligned with Approved Document B was not communicated to UHL stakeholders, leaving them unaware of associated compliance risks. Future projects must ensure that any changes to design standards, assumptions, or regulatory submissions are clearly communicated, formally recorded, and agreed with all relevant stakeholders.

UHL should continue to strengthen early-stage review against HTM and HBN standards. To support this, a formal derogation register should be implemented from the technical design phase and maintained throughout the project lifecycle. This register should include formal declarations from providers confirming either that no derogations exist or that all deviations from applicable standards have been identified, reviewed, and formally agreed. This approach will improve transparency and reduce the risk of unrecognised compliance gaps. Confirmation of the design code used at design phase is key, prior to moving to the building phase of the project.

The project timeline also indicates that concerns raised by Building Control, including those from Peterborough Fire and Rescue Service, were not communicated to UHL in a timely manner. As part of strengthened compliance and project management processes, formal confirmation of feedback from Building Control should be required, including documented evidence where no concerns have been raised. This would enable earlier visibility and intervention by UHL where necessary.

7.5. Fire Experts Early Engagement

Early engagement with external stakeholders, particularly Fire and Rescue Services, is another key learning point. Engagement should take place as early as the concept or design stage wherever possible, including seeking informal guidance where formal consultation routes are not yet available from the Fire Authority. In parallel, UHL's internal fire safety expertise should be appropriately utilised. Where key documents, such as a Fire Strategy, are identified as missing or incomplete, this should be escalated and resolved before the project proceeds further.

8. Concluding remarks

There are clearly lessons to be learnt from the circumstances surrounding the project which have been included within the document in detail. However it should be noted that these recommendations reflect the learning and lessons that the stakeholders themselves have proposed. There is evidence that clear learning and reflection to that end has already taken place and the expertise of the existing renal project team for projects such as this should be recognised along some of the most experienced in the NHS. I would like to take this opportunity to thank those that have contributed their thoughts and reflections into this report. It should be noted that I am not a fire safety expect and conclusions have been drawn based on the expert's evidence provided from stakeholders.

Report Author: Vicki Turner, Head of Contracts and Commissioning, UHL
Date: 5th June 2026

Appendix 1: Terms of Reference



Peterborough TOR Final 04.02.2026.pdf

Appendix 2: Key Timeline of Events

Date	Event	Detail / Outcome
September 2023	Contract Award	A contract was awarded to DaVita following a formal tender process to deliver a new dialysis unit in Peterborough. The unit was intended to accommodate all existing patients and support anticipated growth over the 10-year contract period.
October 2023	Design Team Engagement Begins	Initial engagement with design team. Fire strategy drawing requested by UHL team but only generic plan provided by sub-contractor, with no fire safety detail or strategy.
November 2023	Initial Meeting	First formal meeting held with project/design team. Fire strategy documentation still not provided.
02/07/2024	Initial Consultation Received	Building Control consultation received from SWECO to Peterborough Council (Ref: 66111591).
02/07/2024	Request for Further Information	CFRS requested additional fire safety information due to missing Fire Strategy, evacuation policy, alarm details, emergency lighting, and fire protection measures. No response received.
October 2024	Design Review Meeting	Fire strategy drawing presented but still no formal fire strategy document. Concerns noted regarding compartment sizes and evacuation assumptions.
16/01/2025	Revised Consultation Submitted	SWECO submitted updated drawings including fire strategy embedded in plans. Design identified as non-compliant with HTM guidance (evacuation strategy and compartmentation concerns).
22/01/2025	Non-Compliance Query Raised	CFRS requested clarification regarding HTM non-compliance concerns.
29/01/2025	Design Position Clarified	SWECO confirmed design followed **Approved Document B (ADB)** rather than HTM 05-02, classifying occupancy as "assembly and recreation."
03/02/2025	Challenge to Design Approach	CFRS challenged applicability of ADB classification due to patient dependency levels.
04/03/2025	SWECO Position Maintained	SWECO confirmed satisfaction with compliance under their interpretation. Final correspondence from SWECO.
March 2025	Snagging / Site Review	Joe Clayton (UHL fire team) visited site. Concerns raised that build aligned with ADB rather than HTM 05-02. Fire strategy document still not provided.
05/04/2025	Closure of Existing Units	Mistry Unit and previous Peterborough Dialysis Unit formally closed.
07/04/2025	**New Unit Opened**	**New Peterborough Dialysis Unit opened with 35 stations, expandable to 48.**

Date	Event	Detail / Outcome
07/05/2025	Fire Risk Assessment	FRA conducted by Joe Clayton. Concerns raised regarding evacuation strategy and compliance with HTM vs ADB assumptions.
20/05/2025	**Failure to Agree Letter Issued**	**Formal notice issued stating inability to confirm patient safety and compliance with fire safety legislation.**
23/05/2025	CFRS Site Visit	Gary Doughty (CFRS) visited unit and raised concerns regarding evacuation timing and patient removal from dialysis.
28/05/2025 (AM–PM)	Escalation of Fire Concerns	CFRS raised concerns via email to DaVita regarding evacuation capability. Internal escalation to UHL fire team, Renal and RRCV leadership. Evacuation drill planned (03/06).
28/05/2025	**UHL Operational Awareness of Risk**	**Cambridgeshire Fire & Rescue Service visited the site and subsequently contacted DaVita via email outlining fire safety concerns. This represents the point at which UHL operational teams became aware of the potential risk to the unit's safe functioning.**
29/05/2025	CFRS Technical Discussion	CFRS confirmed submission had been assessed under ADB, raising concerns about evacuation strategy (2–3 minute requirement).
03/06/2025	Emergency Evacuation Drill	Full evacuation exercise completed. Approximately 10 patients evacuated in ~2.5 minutes; full evacuation significantly exceeded benchmark (approx. 12 minutes total reported across accounts).
04/06/2025	**Prohibition / Restriction Notice Issued**	**CFRS issued restriction (Ref: P/02/25). Capacity limited due to inability to demonstrate safe evacuation. (agreed to implement from 06/06/2025.**
06/06/2025	Immediate Capacity Reduction Ordered	CFRS instructed reduction from 25 to 10 patients in main clinical area immediately. Implementation deferred due to operational constraints.
06/06/2025	Agreed Implementation Plan	Agreement reached for restriction to commence 2300 hrs on 09/06/2025, with UHL required to implement mitigations from 06/06 including staffing and fire appliance provision.
07–09/06/2025	Mitigation Period	UHL implemented interim safety measures including staffing increases and fire appliance support pending enforcement.
09/06/2025 2300 hrs	**Capacity Reduced**	**Operational capacity formally reduced from 25 to 10 patients in main clinical area.**
30/06–01/07/2025	Remediation Meetings	Multi-party meetings held (UHL, DaVita, consultants) to explore design remediation options.
02/07/2025	CFRS Senior Meeting	Meeting at Peterborough unit with CFRS, UHL CEO and Patrick Silk. CFRS maintained restriction; UHL chose not to appeal.
Date Not Specified	Building Control Change	Building Control changed from SWECO (Approved Inspector) to Total Building Control (Local Authority Building Control).
22/12/2025	Restriction removed	Fire service restriction formally removed.

Date	Event	Detail / Outcome
23/12/2025	**Capacity Reinstated**	**Unit reopened to all dialysis patients at Westwood Farm Industrial Estate (capacity restored to 35 stations).**
March (post-opening)	Office Works Completion	Remaining office works at Westwood Farm Industrial Estate scheduled for completion.

24 Appendix ‘F’

Estates Return Information Collection (ERIC)

T05_01	Fires recorded	11
T05_02	False alarms - No call out	233
T05_03	False alarms - Call out	76
T05_04	Deaths resulting from fire(s)	0
T05_05	People injured resulting from fire(s)	0
T05_06	Patients sustaining injuries during evacuation	0

25 Appendix 'G'

Supporting documentation

Annual Fire Safety Statement: 2025/26

As required under HTM 05-01:		
University Hospitals of Leicester NHS Trust (UHL)		
I confirm the following for the period 1 April 2025 to 31 March 2026 (please tick/complete the appropriate boxes):		
1.1	An Independent External Audit of the fire management system has been conducted, and a remedial action plan has been implemented	☐
1.2	An internal audit of the fire management system has been conducted, and a remedial action plan has been implemented.	☒
1.3	No fire management system audits have been conducted.	☐
2.1	Fire training performance (measured against the organisation's Training Needs Analysis) is:	89%
3.1	All premises which the organisation owns, occupies or manages have current fire risk assessments in compliance with the Regulatory Reform (Fire Safety) Order 2005.	☒
3.2	There are no significant risks arising from the fire risk assessments	☐
3.3	The organisation has developed a programme of work to eliminate or reduce to a reasonably practicable level the significant risks identified by the risk assessment	☒
3.4	The organisation has identified significant risks, but does not have a programme of work to mitigate those significant risks.	☐
3.5	Where a programme to mitigate significant risks has not been developed, please insert the date by which such a programme will be available, taking account of the degree of risk.	☐
4	During the period covered by this statement, the organisation has been subject to any enforcement action by the fire and rescue authority. Where applicable, please attached copies of enforcement notices and associated action plan/status updates.	☒
5	The organisation has not got any ongoing enforcement action pre-dating this Statement. Where applicable, please attach copies of enforcement notices and associated action plan/status updates.	☒
Notes	1.1) External Fire Audit arranged for 28th May 2026. 4) See Enforcement Information Below <u>Peterborough Dialysis Unit</u> A Restriction Notice was provided to the Peterborough Dialysis Unit on 6th June 2025; the notice was provided with regards to the building design document used and the consequent failure to comply with Articles 8 and 14 of the Fire Safety Order.	

	The Building Managers (Davita) developed design changes with the aid of a new Design Third Party and Fire Engineering Company. Following changes to the floor layout, increased compartmentation and minor alterations to the external means of escape, the restriction was lifted on the 22nd December 2025. The initial Notice from CFRS is provided within Appendix 'D' of the Fire Safety Report; Appendix 'E' is the result of the extensive investigation/report carried out by the Head of Contracts and Commissioning for UHL. This report was provided outside the 2025/26 reporting year but has been included due to the relevant information provided within it. See Section 7 & Appendix D.
Chief Executive	Richard Mitchell (CEO)
Executive Director (Fire)	Julie Hogg (Chief Nurse)
Non Executive Director (Fire)	Ben Widdowson (Director of Estates, Facilities & Sustainability)
Associate Director (Fire)	Michael Blair (Associate Director of Compliance, Health, Safety & Security)
Head of Fire Safety	Robert Hill
Contact Details	Email: robert.hill24@nhs.net
	Telephone: 0116 2588060
	Mobile: 07795 446574
Signature of Chief Executive	
Date	Click here to enter a date.