CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT –NOVEMBER 2016

Authors: John Adler and Stephen Ward Sponsor: John Adler **Trust Board paper D**

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for November 2016 is attached. It includes:-

(a) the Quality and Performance Dashboard for September 2016 attached at appendix 1 (the full month 6 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) the Board Assurance Framework (BAF) Dashboard and Organisational Risk Register Dashboard, attached at appendices 2 and 3, respectively.

(c) key current issues relating to our annual priorities 2016/17.

Questions

1. Is the Trust Board satisfied with our performance and plans on the matters set out in the report?
2. Does the Trust Board have any significant concerns relating to progress against the annual priorities 2016/17?
3. Does the Trust Board have any comments to make regarding either the Board Assurance Framework Dashboard or Organisational Risk Register Dashboard?

Conclusion

1. The Trust Board is asked to consider and comment upon the issues identified in the report.

Input Sought

We would welcome the board's input regarding content of this month's report to the Board.

For Reference

Edit as appropriate:

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

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

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

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

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

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

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

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

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

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

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

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

5. Scheduled date for the **next paper** on this topic: [December 2016 Trust Board]

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **3 NOVEMBER 2016**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – NOVEMBER 2016**

---

1. Introduction

1.1 My monthly update report this month focuses on:-

(a) the Board Quality and Performance Dashboard, attached at appendix 1;

(b) the Board Assurance Framework (BAF) Dashboard and Organisational Risk Register Dashboard, attached at appendices 2 and 3, respectively;

(c) key issues relating to our Annual Priorities 2016/17, and

(d) a range of other issues which I think it is important to highlight to the Trust Board.

1.2 I would welcome feedback on this report which will be taken into account in preparing further such reports for future meetings of the Trust Board.

2. Quality and Performance Dashboard – September 2016

2.1 The Quality and Performance Dashboard for September 2016 is appended to this report **at appendix 1**.

2.2 The Dashboard aims to ensure that Board members are able to see at a glance how we are performing against a range of key measures.

2.3 The more comprehensive monthly Quality and Performance report continues to be reviewed in depth at meetings of the Integrated Finance, Performance and Investment Committee and Quality Assurance Committee, respectively. The month 6 quality and performance report continues to be published on the Trust's website.

Good News

2.4 **Mortality** – although the latest published SHMI (covering the period April 2015 to March 2016) has increased to **99**, it is still within Quality Commitment goal of **99**. Further detailed analysis is underway to understand what is causing SHMI to increase. **Moderate harms and above** – there have been some increases to the previous month's figures following review and CMG sign off. However, we remain well within the agreed Quality Commitment monthly thresholds. **Readmission rates** – at 8.4% we have achieved delivery against the 8.5% target for the second consecutive month. **Referral to Treatment 52+ week waits –** the current number is 53 and we remain on target to be at zero by the end of January. The **Cancer Two Week Wait** was achieved in August and is expected to remain compliant. **Delayed transfers of care** remain within the tolerance with an improved position noted this month. **MRSA** – 0 cases reported this month. **C DIFF** – 8 unrelated cases reported in

September, with year to date 1 above trajectory. **Pressure Ulcers** – 0 **Grade 4** pressure ulcers reported this year and **Grade 3 and Grade 2** added together are within the year to date trajectory. **Patient Satisfaction (FFT)** is back up to 97% for Inpatients and Day Cases following a dip in August. **ED FTT coverage** remains below the threshold of 20% but improved to 12% during September.

Bad News

2.5 **ED 4 hour performance** – September performance was 79.8% with year to date performance at 79.7%. Contributing factors are set out in the Chief Operating Officer's report. **Ambulance Handover 60+ minutes** – performance deteriorated in September to 9%; this is also examined in detail in the Chief Operating Officer's report. **RTT** – the RTT incomplete target was non-compliant at 91.7% for the first time since December 2013. This was due to an increase in referrals, cancelled operations and issues associated with Alliance patient activity. The **Diagnostics** target was missed partly due to the installation of EMRAD. **Cancelled operations** and **patients rebooked within 28 days** – continue to be non-compliant, due to ITU/HDU and emergency pressures. **Cancer Standards 62 day treatment** - remains non-compliant although on a positive note there have been continued improvements in backlog numbers. In discussion with NHS Improvement and NHS England the Trust has stated that it cannot confirm recovery of the key cancer standards until there has been a sustained period of ring-fenced capacity of elective beds, i.e. >2 months. **Fractured NOF** – target missed for the third time this year. The Medical Director is leading a piece of work to improve this. **Patient Satisfaction (FFT)** for ED hit a low of 84% during September – ED minors and UCC come out with very poor scores which needs investigating further. **Statutory & Mandatory Training** – performance has dropped to 88% against a target of 95%, as 1,500 former Interserve staff have been transferred over to UHL's Estates and Facilities Directorate. **Single Sex Accommodation Breaches** – numbers increased in September reflecting increasing pressures in the emergency care pathway.

3. <u>Board Assurance Framework (BAF) and Organisational Risk Register Dashboards</u>

3.1 As part of a new risk reporting process, the Board Assurance Framework and risks taken from the UHL organisational risk register scoring from 15 to 25 (ie extreme and high) are now summarised in two 'dashboards' **attached to this report as appendices 2 and 3**.

3.2 The full Board Assurance Framework features elsewhere on the agenda for this meeting of the Trust Board as part of the Integrated Risk Report.

Board Assurance Framework Dashboard

3.3 Executive Director risk owners have updated their BAF entries to reflect the risks and assurances in relation to the 2016/17 annual priorities. The Trust Board is asked to note:

- Principal risk 4: the current risk rating has been increased to 20 (from 16).
- Principal risk 7: the Trust was awarded Biomedical Research Centre status on 13th September 2016; therefore achieving this status is no longer a risk. However, the amount of funding awarded was less then requested, which may result in a new risk – this depends on how the application is re-profiled and accepted by the National Institute for Health Research – this is currently being considered.
- Principal risks 10 and 11: these risks will be reviewed and updated for the December 2016 meeting of the Trust Board.
- Principal risk 13: the capital availability to progress all reconfiguration projects within a reduced funding allocation is still unknown and it is hoped that this will be clear during Q3 2016/17.

- Principal risk 16: the current risk rating has been increased to 20 (from 15).
- Principal risk 18: there continues to be a lack of progress in addressing the approvals by NHS Improvement for the UHL EPR programme and in light of the on-going consequences, the Chief Information Officer will review the current risk rating and will report his findings to the Executive IM&T Board meeting scheduled for 29th November 2016.

Organisational Risk Register

3.4 There are currently 52 risks open on the organisational risk register with a current risk rating of 15 and above (i.e. scoring high and extreme). There have been five new high risks entered on the risk register during the reporting period. The Trust Board is asked to note:

1. there is a risk that the damaged flooring in Wards 42 and 43 may result in trip and fall incidents;
2. there is a risk of the Cardiac Monitoring System on CCU failing to operate;
3. there is a risk that paediatric cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care and other services;
4. there is a risk that nurse staffing vacancies in Oncology may result in suboptimal care to patients;
5. there is a risk that the use of electronic and paper drug charts on Ward 26 at LGH may result in drug errors.

3.5 Thematic analysis of the risk register continues to reveal the majority of risks scoring 15 and above are caused by gaps in workforce capacity and capability with the potential to impact on clinical safety, quality and performance.

4. <u>Strategic Objective: Safe, High Quality Patient Centred Care</u>

2016 Care Quality Commission (CQC) Inspection

4.1 I anticipate that we will soon receive the draft CQC reports following the inspections carried out earlier this year.

4.2 The Trust has the opportunity to comment on the draft reports on the grounds of factual accuracy and 12 working days are allowed for this task. Consequently, and subject to review of the draft reports when received, I anticipate that the CQC will look to publish the final versions of the reports in either November or December 2016. As with the previous inspection in 2014, we will then develop detailed action plans to address areas identified as in need of improvement. We will also of course celebrate areas of strength.

5. <u>Strategic Objective: An Excellent, Integrated, Emergency Care System</u>

Emergency Care Performance

5.1 Our performance against the 4 hour standard remains very challenged. A detailed report from the Chief Operating Officer features elsewhere on this agenda. Although we are tackling many aspects of our emergency care system, recent discussions have clearly identified two key themes on which we need to focus. These are:

- improving the way in which ED itself functions, in particular improving consistency of process, floor management and escalation

- ratcheting up our efforts to improve patient flow through our assessment units and base medical wards through the rapid roll out of the SAFER bundle and Red/Green days methodology.

5.2 We are developing refreshed approaches to addressing both of the above issues. This includes identifying significantly greater project capacity for the ward flow work.

6. Strategic Objective: Services which consistently meet National Access Standards

Overall Performance

6.1 I have already touched on emergency performance above, but I am sorry to have to report that we failed to achieve a number of key performance standards in September 2016 including the RTT incomplete target and both the 31 and 62 day wait cancer standards.

6.2 Compliance with all of the standards in the ‘Responsive’ section of our Quality and Performance Dashboard on a sustainable basis remains challenging given the continuing emergency care pressures and very high referral rates for both the elective and cancer pathways. This combination continues to cause cancellations, due to all of theatre, base ward and ICU/HDU capacity shortfalls. These pressures are likely to increase over the winter. Unfortunately, our key mitigating action (opening an additional medical ward) is proving difficult to deliver due to an inability to recruit sufficient staff. This position is being kept under review and the additional ward will be opened as soon as it is safe to do so. This will in turn increase our chances of protecting surgical capacity from emergency medical pressures.

6.3 These issues continue to receive close attention at Executive-level, including at the monthly meeting of the Executive Performance Board, and at the Integrated Finance, Performance and Investment Committee.

7. Strategic Objective: Integrated Care in Partnership with Others

Sustainability and Transformation Plan (STP)

7.1 We discussed the latest draft of the STP at our private Board meeting on 17th October 2016 and a number of Board members joined me and colleagues from LLR Partner Boards at a meeting on 18th October 2016 to discuss the STP submission to NHS England and NHS Improvement.

7.2 A further draft iteration of the LLR STP was submitted to those bodies on 21st October 2016, as required, and feedback is awaited.

7.3 We anticipate being in a position to publish key details of the LLR STP once such feedback has been received.

7.4 Although it is not possible to publish details of the draft STP at this stage (as instructed by NHS England), it is fair to say that developing a “balanced” STP (i.e. one that lives within the financial resources available whilst still achieving all the national “must do” objectives) is proving to be extremely challenging. Having said that, the severity of the situation has driven more radical thinking and it is likely that several positive initiatives will come out of this process.

8. Strategic Objective: An Enhanced Reputation in Research, Innovation and Clinical Education

General Medical Council (GMC) – Visit – 25th October 2016

8.1 As part of their East Midlands regional review, the GMC conducted a quality assurance visit at the Trust on 25th October 2016 to evaluate the quality of undergraduate and postgraduate medical education.

8.2 The specialties visited were Anaesthetics, Cardiology, Gastroenterology, Acute Internal Medicine, General Internal Medicine, Core Medical Training and Foundation Training.

8.3 The GMC inspection team met a large selection of medical students, trainees and trainers during their visit and we expect formal feedback in two to three months time.

8.4 Much of the initial feedback received at the end of the visit, notably around the Trust's commitment to medical education and the quality of the approach of our Medical Education department, was very positive. There will undoubtedly be areas for improvement as well. As part of the inspection process, the GMC have a remit to identify and report back any serious patient safety concerns (which may or may not relate to medical education per se). No such concerns were identified during this inspection.

'Academic Champions'

8.5 On 17th October 2016, I had the pleasure of attending a dinner hosted by Professor Philip Baker, Pro Vice-Chancellor and Head of College of Medicine, Biological Sciences and Psychology at the University of Leicester (and UHL Non-Executive Director) which marked the inaugural induction event for a network of Academic Champions, many of whom are senior NHS clinicians at UHL. The Champions act as facilitators for those doctors in training who seek to further their careers by working in collaboration with the University of Leicester, and help them reach their full potential.

8.6 This is an exciting development as not only will these individuals play an important role in helping to develop the education and research aspirations of our medical students and junior doctors in training, but also help to improve recruitment and retention of the medical workforce.

8.7 I would like to pay tribute to Professor Baker's continuing efforts to strengthen the University's relationship with the Trust through targeted initiatives such as this.

9. Strategic Objective: A Caring, Professional, Passionate and Engaged Workforce

Leicester Children's Hospital Showcase

9.1 On 7th October 2016, I had the pleasure of chairing the first Leicester Children's Hospital Showcase event. We celebrated the 20 year anniversary of the opening of the Children's Intensive Care Unit and reflected on the work being done in the Children's Hospital, with teams from the hospital sharing their work through posters, presentations and stands. An update on the progress of the new Children's Hospital development also featured.

9.2 Approximately 150 people attended the event from not only UHL but other local healthcare organisations and we were also pleased to be joined by colleagues from the University of Leicester, De Montfort University and a number of our local Members of Parliament and Councillors.

9.3 The event was a great success and underlined the caring, professional, passionate and engaged nature of our Children's Hospital workforce.

10. Strategic Objective : A Clinically Sustainable Configuration of Services, operating from Excellent Facilities

East Midlands Congenital Heart Centre

10.1 I note here that the Board is to receive a separate report at this meeting on the importance subject of the proposal by NHS England to cease the commissioning of children's heart surgery at the Trust.

Vascular Service Relocation to Glenfield

10.2 The Executive Team has made the decision to go ahead with the move of vascular services to the Glenfield. This was originally intended to happen in parallel with the ITU and related moves from the General but these are currently delayed awaiting capital funding. The vascular move is going ahead as our surgeons need access to the new hybrid theatre to provide the best care and locating our cardiovascular services in one place is a key part of our reconfiguration plans. The move will also free up much needed ward and theatre space at the Royal.

10.3 The Ward (23), angiography suite and Vascular Studies unit were completed in September and the hybrid theatre construction is due to complete in December. Now that we have decided to use Ward 23 to support winter pressures at Glenfield between December and the end of March 2017, it means that the move will take place on 8 May 2017.

10.4 Detailed work will now be done over the coming months to ensure a successful service transfer. It is very important that we progress this as it is a key part of our reconfiguration plans.

Single Oversight Framework: Shadow Segmentation

10.5 On 21st October 2016, NHS Improvement published its shadow segmentation of all NHS Trusts and Foundation Trusts, according to their support needs. This follows NHS Improvement's publication of its new Single Oversight Framework in September 2016 which set out a new mechanism of categorising Trusts according to their performance against a number of metrics across five themes (quality of care; finance and use of resources; operational performance; strategic change; leadership and improvement capability).

10.6 UHL has been placed in segment 3 – "mandated support". This means that the Trust is judged to be in actual/suspected breach of its 'licence to operate' and/or requires formal action, as determined by NHS Improvement, to help address specific issues and help the Trust to move to either segment 2 or 1 (segment 2 – targeted support; segment 1 – maximum autonomy).

10.7 The majority (60%) of providers are in segments 1 and 2. However, when broken down by Trust type, the significant pressures being faced by both the ambulance and acute sectors become apparent with two thirds of acute Trusts and half of ambulance Trusts in segments 3 and 4 (segment 4 – special measures).

10.8 The segmentation is based on performance data and other information gathered by NHS Improvement before the Single Oversight Framework came into place on 1st October 2016. The primary drivers of our segmentation are emergency care performance and our financial

deficit (although I do not think that there is currently a perception that we need intervention on the latter of these). Mandated support around emergency care currently takes the form of ECIP; it is possible that this may escalate if performance does not improve e.g. an ED Special Measures regime has been trailed similar to that already in place for Finance (which has not been applied to UHL).

10.9 NHS Improvement will be working with the Trust and other providers to help identify the best support each Trust requires. This support will include sector-led support, as well as direct support from NHS Improvement in some cases. The first formal segmentation will follow in November 2016.

11. Strategic Objective: A Financially Sustainable NHS Trust

Financial Performance for the period ending 30th September 2016

11.1 I am sorry to have to report that we incurred a £2M adverse variance in September 2016. Despite this, we are continuing to forecast to deliver our planned deficit of £8.3M through the execution of recovery plans but, also, via a series of additional actions to be taken across the organisation which are to be considered further by the Executive Team at its meeting on 1st November 2016. I will report orally on these measures at the Board meeting on 3rd November 2016.

11.2 There is considerable financial risk in the second half of the year and we will need to maintain tight control and fully deliver our Cost Improvement Programme (noting that this is currently ahead of plan) to deliver our planned deficit.

11.3 The detailed financial position of the Trust continues to be scrutinised at the monthly meeting of the Integrated Finance, Performance and Investment Committee, most recently on 27th October 2016. A report from that Committee meeting features separately on this agenda of the Board.

Agency Spend Reduction and Capped Rates for Agency Staff

11.4 During October 2016, NHS Improvement issued further guidance on actions to be taken to reduce agency spending including promoting transparency, better data, stronger accountability to Boards and additional reporting of high-cost overrides.

11.5 At UHL, agency expenditure in 2016/17 to date is £12.7M compared to planned expenditure of £11.4M, representing a £1.3M adverse variance to plan.

11.6 Trust Boards have been asked to complete a self-certification checklist on agency spending for submission to NHS Improvement by 30th November 2016. Recognising the importance of this issue, provision has been made within the agenda for the Board Thinking Day session on 10th November 2016 to discuss and complete the checklist provisionally, with the final version to be submitted to the Integrated Finance, Performance and Investment Committee on 24th November 2016 for formal approval before submission to NHS Improvement.

12. Strategic Objective: Enabled by Excellence IM&T

Electronic Patient Record (EPR) Business Case

12.1 I regret to report that there has been no further communication from NHS Improvement on the question of when our business case will be considered by the National Approval Committee.

12.2 Recognising the length of time we have been awaiting approval of our business case, we now need to take stock of the position and consider contingency arrangements.

12.3 The Chairman has agreed that, in the first instance, we will consider this matter further as part of our Trust Board Thinking Day to be held on 8th December 2016.

13. Conclusion

13.1 The Trust Board is invited to consider and comment upon this report and the attached appendices.

John Adler
Chief Executive

27th October 2016

Quality & Performance

		YTD		Sep-16			Compliant
		Plan	Actual	Plan	Actual	Trend*	by?
Safe	**S1: Reduction for moderate harm and above (1 month in arrears)**	236	54	20	11	🟢	
	S2: Serious Incidents	49	19	4	2	🟢	
	S10: Never events	0	1	0	0	🟢	
	S11: Clostridium Difficile	61	31	5	8	🔴	Oct-16
	S12: MRSA (All)	0	1	0	0	🟢	
	S13: MRSA (Avoidable)	0	0	0	0	🟢	
	S16: Falls per 1,000 bed days for patients > 65 years	<5.6	5.8	<5.6	5.8	🔴	
	S17: Avoidable Pressure Ulcers Grade 4	0	0	0	0	🟢	
	S18: Avoidable Pressure Ulcers Grade 3	33	16	4	2	🟢	
	S19: Avoidable Pressure Ulcers Grade 2	89	45	7	6	🟢	
Caring	**C1: Improvements in Patient Involvement Scores - baseline**	*70%*	64%	*70%*	64%		
	C4: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	🟢	
	C7: A&E friends and family - % positive	97%	91%	97%	84%	🔴	Oct-16
Well Led	**W1: Outpatient letters sent within 14 days (Quarterly)**	*51%*	Achieved	*51%*	Achieved		
	W14: % of Staff with Annual Appraisal	95%	91.5%	95%	91.5%	🔴	
	W15: Statutory and Mandatory Training	95%	82%	95%	82%	🔴	
	W17 BME % - Leadership (8A – Including Medical Consultants)	28%	25%	28%	25%		
	W18: BME % - Leadership (8A – Excluding Medical Consultants)	28%	12%	28%	12%		
Effective	**E1: 30 day readmissions (1 month in arrears)**	<8.5%	8.5%	<8.5%	8.4%	🟢	
	E2: Mortality Published SHMI (Apr 15 -Mar 16)	99	99	99	99	🔴	
	E6: # Neck Femurs operated on 0-35hrs	72%	72.7%	72%	69.4%	🔴	
	E8: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	83.8%	80%	88.0%	🟢	
Responsive	R1: ED 4hr Waits UHL+UCC - Calendar Month	95%	79.7%	95%	79.8%	🟢	
	R3: RTT waiting Times - Incompletes (UHL+Alliance)	92%	91.7%	92%	91.7%	🔴	See Note 1
	R5: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	1.5%	<1%	1.5%	🔴	Oct-16
	R11: Operations cancelled (UHL + Alliance)	0.8%	1.2%	0.8%	1.0%	🟢	See Note 1
	R13: Delayed transfers of care	3.5%	2.2%	3.5%	2.1%	🟢	
	R14: % Ambulance Handover >60 Mins (CAD+)	TBC	7%	TBC	9%	🔴	May-17
	R15: % Ambulance handover >30mins & <60mins (CAD+)	TBC	13%	TBC	15%	🔴	May-17
	RC9: Cancer waiting 104+ days	0	7	0	7	🟢	

		YTD		Aug-16			Compliant
		Plan	Actual	Plan	Actual	Trend*	by?
Responsive	RC1: 2 week wait - All Suspected Cancer	93%	92.0%	93%	94.3%	🟢	
	RC3: 31 day target - All Cancers	96%	93.7%	96%	91.5%	🔴	Nov-16
	RC7: 62 day target - All Cancers	85%	77.9%	85%	78.4%	🟢	See Note 1

Enablers

		YTD		Qtr2 16/17		
		Plan	Actual	Plan	Actual	
People	W8: Staff recommend as a place to work	N/A	61.6%	N/A	62.8%	🟢
	C10: Staff recommend as a place for treatment	N/A	74.2%	N/A	76.0%	🟢

		YTD		Sep-16		
		Plan	Actual	Plan	Actual	Trend*
Finance	Surplus/(deficit) £m	(7.9)	(7.9)	0.5	1.2	🟢
	Cashflow balance (as a measure of liquidity) £m	3.2	5.7	3.2	5.7	🔴
	CIP £m	15.4	16.1	3.1	2.6	🔴
	Capex £m	29.3	28.3	5.3	4.1	🟢

		YTD		Sep-16		
		Plan	Actual	Plan	Actual	Trend*
Estates & facility mgt.	Percentage of Cleaning Audits achieving the required standard	100%	**86%**	100%	**87%**	🟢

* Trend is green or red depending on whether this month's actual is better or worse than the average of the prior 6 months

Please note: Quality Commitment Indicators are highlighted in bold. The above metrics represent the Trust's current priorities and the code preceding many refers to the metrics place in the Trust's Quality & Performance dashboards. Please see these Q&P dashboards for the Trust's full set of key metrics.

Note 1 - The STF trajectory for RTT and 62 Cancer is **'Compliant by?'** Oct-16. **'Compliant by?'** for both these metrics and cancelled operations are dependent on the Trust rebalancing demand and capacity.

UHL Board Assurance Dashboard:	SEPTEMBER 2016								
Strategic Objective	**Risk No.**	**Principal Risk Description**	**Owner**	**Current Risk Rating**	**Target Risk Rating**	**Risk Movement**	**Assurance Rating**	**Executive Board Committee for Endorsement**
Safe, high quality, patient centered healthcare	1	Lack of progress in implementing UHL Quality Commitment.	CN	12	8	↔		EQB
	2	Failure to provide an appropriate environment for staff/ patients	DEF	16	8	↑		EQB
An excellent integrated emergency care system	3	Emergency attendance/ admissions increase without a corresponding improvement in process and / or capacity	COO	25	6	↔		EPB
Services which consistently meet national access standards	4	Failure to deliver the national access standards impacted by operational process and an imbalance in demand and capacity.	COO	20	6	↑		EPB
Integrated care in partnership with others	5	There is a risk that UHL will lose existing, or fail to secure new, tertiary referrals flows from partner organisations which will risk our future status as a teaching hospital. Failure to support partner organisations to continue to provide sustainable local services, secondary referral flows will divert to UHL in an unplanned way which will compromise our ability to meet key performance measures.	DoMC	12	8	↔		ESB
	6	Failure to progress the Better Care Together programme at sufficient pace and scale impacting on the development of the LLR vision	DoMC	16	10	↔		ESB
Enhanced delivery in research, innovation and clinical education	7	Failure to achieve BRC status. Status awarded on 13th September 2016.	MD	6	6	↓		ESB
	8	Failure to deliver an effective learning culture and to provide consistently high standards of medical education	MD / DWOD	12	6	↔		EWB / EQB
	9	Insufficient engagement of clinical services, investment and governance may cause failure to deliver the Genomic Medicine Centre project at UHL	MD	12	6	↔		ESB
A caring, professional and engaged workforce	10a	Lack of supply and retention of the right staff, at the right time, in the right place and with the right skills that operates across traditional organisational boundaries	DWOD	16	8	No update rec'd Sep	No update rec'd Sep	EWB / EPB
	10b	Lack of system wide consistency and sustainability in the way we manage change and improvement impacting on the way we deliver the capacity and capability shifts required for new models of care	DWOD	16	8	No update rec'd Sep	No update rec'd Sep	EWB / EPB
	11	Ineffective structure to deliver the recommendations of the national 'freedom to speak up review'	DWOD	12	8	No update rec'd Sep	No update rec'd Sep	EWB / EPB
A clinically sustainable configuration of services, operating from excellent facilities	12	Insufficient estates infrastructure capacity may adversely affect major estate transformation programme	CFO	16	12	↔		ESB
	13	Limited capital envelope to deliver the reconfigured estate which is required to meet the Trust's revenue obligations	CFO	16	8	↔		ESB
	14	Failure to deliver clinically sustainable configuration of services	CFO	20	8	↔		ESB
A financially sustainable NHS Trust	15	Failure to deliver the 2016/17 programme of services reviews, a key component of service-line management	CFO	9	6	↔	Under review	ESB
	16	The Demand/Capacity gap if unresolved may cause a failure to achieve UHL deficit control total in 2016/17	CFO	20	10	↑		EPB
	17	Failure to achieve a revised and approved 5 year financial strategy	CFO	15	10	↔		EPB
Enabled by excellent IM&T	18	Delay to the approvals for the EPR programme	CIO	16	6	↔		EIM&T / EPB
	19	Lack of alignment of IM&T priorities to UHL priorities	CIO	9	6	↓		EIM&T / EPB

Risk Register Dashboard for period ending 30/09/16

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with BAF
2236	ESM	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	25	16	Ian Lawrence	↔		Effective emergency care
2762	Corporate Nursing	Ability to provide safe, appropriate and timely care to all patients attending the Emergency Department at all times.	25	15	Julie Smith	↔		Effective emergency care
2924	CHUGGS	There is a risk that the damaged flooring in Wards 42 and 43 may result in trip and fall incidents	20	2	Georgina Kenney	NEW		Safe, high quality, patient centred healthcare
2931	RRCV	Increasing frequency of Cardiac Monitoring System on CCU failing to operate	20	4	Sue Mason	NEW		Safe, high quality, patient centred healthcare
2670	RRCV	There is a risk to the Immunology & Allergy Services due to a Consultant Vacancy	20	6	Sue Mason	↔		Workforce capacity and capability
2354	RRCV	There is a risk of overcrowding in the Clinical Decisions Unit	20	9	Sue Mason	↔		Effective emergency care
2149	ESM	High nursing vacancies across the ESM CMG impacting on patient safety, quality of care and financial performance	20	6	Gill Staton	↔		Workforce capacity and capability
2804	ESM	Outlying Medical Patients into other CMG beds due to insufficient ESM inpatient bed capacity	20	12	Gill Staton	↔		Effective emergency care
2333	ITAPS	Lack of Paediatric cardiac anesthetists to maintain a WTD compliant rota leading to interruptions in service provision	20	8	Rachel Patel	↔		Workforce capacity and capability
2763	ITAPS	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity	20	10	Heather Allen	↔		Workforce capacity and capability
2787	CSI	Failure of medical records service delivery due to delay in electronic document and records management (EDRM) implementation	20	4	Debbie Waters	↔		Workforce capacity and capability
2562	W&C	There is a risk that 2 vacant consultant paediatric neurology vacancies could impact sustainability of the service	20	4	J Visser	↔		Workforce capacity and capability
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Alison Poole	NEW		Safe, high quality, patient centred healthcare
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	Elizabeth Collins	↔		Estates and Facilities services
2404	Corporate Nursing	There is a risk that inadequate management of Vascular Access Devices could result in increased morbidity and mortality	20	16	Elizabeth Collins	↔		Safe, high quality, patient centred healthcare
2823	CHUGGS	There is a risk of errors with patient medical review appointment and chemotherapy appointments due to gaps in admin workforce.	12	6	Kerry Johnston	↓ (16 to 12)		Workforce capacity and capability
2471	CHUGGS	There is a risk of poor quality imaging due to age of equipment resulting in suboptimal radiotherapy treatment.	16	4	Lorraine Williams	↔		Safe, high quality, patient centred healthcare
2264	CHUGGS	Risk to the quality of care and safety of patients due to reduced staffing in GI medicine/Surgery and Urology at LGH and LRI	16	6	Georgina Kenney	↑ (12 to 16)		Workforce capacity and capability

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with BAF
2923	CHUGGS	There is a risk that nurse staffing vacancies in Oncology may result in suboptimal care to patients	16	6	Kerry Johnston	NEW		Workforce capacity and capability
2905	RRCV	There is a risk of delays to patient diagnosis and treatment which will affect the delivery of the national 62 day cancer target	16	6	Karen Jones	↔		Workforce capacity and capability
2870	RRCV	Audit of DNACPR form have shown that the discussion with the patient or family is not consistently recorded	16	2	Elved Roberts	↔		Safe, high quality, patient centred healthcare
2791	RRCV	Broadening Foundation - Loss of F1 doctors	16	2	Sue Mason	↔		Workforce capacity and capability
2819	RRCV	Risk of lack of ITU and HDU capacity will have a detrimental effect on Vascular surgery at LRI	16	12	Paul Saunders	↔		Workforce capacity and capability
2820	RRCV	Risk that a timely VTE risk assessment is not performed on admission to CDU meaning that subsequent actions are not undertaken	16	3	Sue Mason	↔		Safe, high quality, patient centred healthcare
2193	ITAPS	There is a risk that the ageing theatre estate and ventilation systems could result in an unplanned loss of capacity at the LRI	16	4	Gaby Harris	↔		Workforce capacity and capability
2541	MSK & SS	There is a risk of reduced theatre & bed capacity at LRI due to increased spinal activity	16	8	Carolyn Stokes	↔	X	Workforce capacity and capability
2191	MSK & SS	There is a risk of lack of capacity within the service causing follow up backlogs and capacity issues in Ophthalmology	16	8	Clare Rose	↔		Workforce capacity and capability
2687	MSK & SS	Lack of appropriate medical cover will clinically compromise care or ability to respond in Trauma Orthopaedics	16	9	Carolyn Stokes	↔		Workforce capacity and capability
2607	CSI	There is a risk that the provision of an out of hours Virology "On-call" service may not be sustained due to insufficient staff	16	6	Jilean Bowskill	↑ (12 to 16)		Workforce capacity and capability
1206	CSI	There is a risk that a backlog of unreported images in plain film chest and abdomen could result in a clinical incident	16	6	ARI	↔		Workforce capacity and capability
182	CSI	POCT- Inappropriate patient Management due to inaccurate diagnostic results from Point Of Care Testing (POCT) equipment	16	2	Lianne Finnerty	↔		Workforce capacity and capability
2378	CSI	There is a risk that Pharmacy workforce capacity could result in reduced staff presence on wards or clinics	16	8	Claire Ellwood	↔		Workforce capacity and capability
1926	CSI	There is a risk that insufficient staffing to manage ultrasound referrals could impact Trust operations and patient safety	16	6	Cathy Lea	↔		Workforce capacity and capability
2391	W&C	There is a risk of inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	8	Cornelia Wiesender	↔		Workforce capacity and capability
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	HKI	↔		Workforce capacity and capability
2394	Comms	No IT support for the clinical photography database (IMAN)	16	1	Simon Andrews	↔		IM&T services
2338	Corporate Medical	There is a risk of patients not receiving medication and patients receiving the incorrect medication due to an unstable homecare	12	9	Claire Ellwood	↓ (16 to 12)		Workforce capacity and capability
2237	Corporate Medical	There is a risk of results of outpatient diagnostic tests not being reviewed or acted upon resulting in patient harm	16	8	Angie Doshani	↔		Workforce capacity and capability

Risk ID	CMG	Risk Title	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Elapsed risk deadline	Themes aligned with BAF
2325	Corporate Medical	There is a risk that security staff not assisting with restraint could impact on patient/staff safety	16	6	Neil Smith	↔		Estates and Facilities services
2247	Corporate Nursing	There is a risk that a significant number of RN vacancies in UHL could affect patient safety	16	12	Maria McAuley	↔		Workforce capacity and capability
1693	Operations	There is a risk of inaccuracies in clinical coding resulting in loss of income	16	8	John Roberts	↔		Workforce capacity and capability
2878	Operations	There is a risk of cancer patients not being discussed at MDTs due to inadequate video conferencing facilities	16	4	Charlie Carr	↔		IM&T services
2935	CHUGGS	Use of dual sofia and paper drug charts on Ward 26 LGH, there is increased risk of drug errors resulting in patient harm	15	1	Clair Riddell	NEW		Safe, high quality, patient centred healthcare
2872	RRCV	There is a risk of bedded bariatric patients being trapped compromising fire evacuation on ward 15 at GGH	15	6	Sue Mason	↔		Safe, high quality, patient centred healthcare
2836	ESM	There is a risk of single sex breaches on the Brain Injury Unit due to environmental design and inflow of patients.	15	2	Holly Bertalan	↔		Safe, high quality, patient centred healthcare
2837	ESM	There is a risk of delay in acting upon monitoring investigation results in patients with multiple sclerosis.	15	2	Ian Lawrence	↔		Safe, high quality, patient centred healthcare
2769	MSK & SS	There is a risk of cross infection of MRSA as a result of unscreened emergency patients being cared for in the same ward bays	15	5	Kate Ward	↔	X	Workforce capacity and capability
510	CSI	There is a risk of staff shortages impacting on the Blood Transfusion Service at UHL	15	15	AFE	↔		Workforce capacity and capability
2162	CSI	Cellular Pathology - Failure to meet TATs	15	6	Mike Langford	↑ (12 to 15)		Safe, high quality, patient centred healthcare
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	DMAR	↔		Workforce capacity and capability
2330	Corporate Medical	Risk of increased mortality due to ineffective implementation of best practice for identification and treatment of sepsis	15	6	JPARK	↔		Safe, high quality, patient centred healthcare
2925	Estates & Facilities	Reduction in capital funding may lead to a failure to deliver the 2016/17 medical equipment capital replacement programme	15	10	Darryn Kerr	↔		Safe, high quality, patient centred healthcare
2402	Corporate Nursing	There is a risk that inappropriate decontamination practice may result in harm to patients and staff	15	3	Elizabeth Collins	↔		Safe, high quality, patient centred healthcare
2774	Operations	Delay in sending outpatient letters following consultations is resulting in a significant risk to patient safety & experience .	15	6	William Monaghan	↔		Workforce capacity and capability