CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – AUGUST 2017

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Trust Board paper D

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for August 2017 is attached. It includes:-

(a) the Quality and Performance Dashboard for June 2017 attached at appendix 1 (the full month 3 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 issues relating to our Strategic Objectives and Annual Priorities 2017/18

Questions

1. Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?
2. 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 [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 [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: [7 September 2017 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 AUGUST 2017**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – AUGUST 2017**

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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 2017/18, 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 – May 2017

2.1 The Quality and Performance Dashboard for June 2017 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 a joint meeting of the Integrated Finance, Performance and Investment Committee and Quality Assurance Committee. The month 3 quality and performance report is published on the Trust's website.

Good News:

2.4 **Mortality** – the latest published SHMI (period January 2016 to December 2016) has reduced to 101 and remains within the expected range. **Referral to Treatment –** was achieved and **diagnostic 6 week wait –** remains compliant for the 9th consecutive month. **52+ week waits –** current number this month is 15 patients (last June the number was 130). **Cancer Two Week Wait** – have continued to achieve the 93% threshold for 11 consecutive months. D**elayed transfers of care** - remain

within the tolerance. However, there are a range of other delays that do not appear in the count. **Never events** – 0 reported this month. **MRSA** – zero cases reported for first quarter. **C DIFF** although there were 10 cases reported in June, YTD remains within threshold. **Pressure Ulcers** – Zero **Grade 4** pressure ulcers reported this financial year, **Grade 3 and Grade 2** are within the trajectory year to date. However there were 5 Grade 3 ulcers in June and this is spike is under investigation. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured NOF** – was achieved May and June. **Ambulance Handover 60+ minutes (CAD+)** – performance at 2% is a significant improvement – this is by far the best performance since the introduction of CAD+ reporting in June 2015. **TIA (high risk patients)** is compliant following a couple of months of non-compliance.

Bad News:

2.5 **Moderate harms and above** – 20 cases reported during May (reported 1 month in arrears). **ED 4 hour performance** – June performance was 77.6%. Further detail is in the Chief Operating Officer's report. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant, predominantly due to emergency pressures. **Cancer 62 day treatment and 31 day treatment –** was not achieved in May. **Single Sex Accommodation Breaches** – 1 breach during June. **Statutory & Mandatory Training** – 82% against a target of 95%.

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

3.1 As part of the 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 leads have updated their entries in the BAF to reflect the current position for June 2017. The detailed BAF, featured elsewhere on the Trust Board agenda, defines that for the majority of the 2017/18 annual priorities there are moderate risks associated, however, at the time of this reporting all priorities are forecast to be delivered by year-end.

3.4 The BAF will continue to be reviewed by the Executive Team to scrutinise the assurance ratings and monitor progress with managing the strategic risks that threaten delivering our annual priorities.

Organisational Risk Register

3.5 There are currently 47 risks open on the operational risk register with a current risk rating of 15 and above (i.e. scoring high and extreme) for the reporting period ending

June 2017. During the month of June 2017 six new high risks have been entered on the risk register.

3.6 Thematic analysis of the risks scoring 15 and above on the risk register shows that the majority of risks are caused by workforce challenges, in particular around capacity and capability, with the potential to have an impact on harm and performance.

3.7 In line with the reporting arrangements described in the risk management policy, a copy of the full risk register report, for items scoring 15 and above, is included as an appendix to the integrated risk and assurance paper, featured elsewhere on the Trust Board agenda.

4. Strategic Objectives and Annual Priorities for 2017/18

Emergency Care

4.1 Emergency performance is still very poor, placing us amongst the worst in the country for 4 hour Emergency Department performance.

4.2 Although we have a programme of work in place to address the causes of this failure (the 'Organisation of Care' programme within our Quality Commitment), our efforts have not had enough impact and this has meant that many emergency patients continue to have a poor experience. We therefore need to work together to improve the position, and quickly.

4.3 Over the last few weeks, we have been reworking our approach and trying to address some long standing issues – some of these relate to how our hospitals and teams work together. I have briefed the Leadership Community about the approach we are going to take over the last week in dedicated briefing sessions and the report from me which features elsewhere on this agenda sets out details of our approach.

Key Strategic Enabler – Leicester, Leicestershire and Rutland Better Care Together and UHL Reconfiguration Programme

4.4 On 19th July 2017, NHS England announced that our Better Care Together partnership will receive investment of almost £40m, starting this year. This marks an important step forward for the healthcare system in Leicester, Leicestershire and Rutland the total funds available nationally at this stage were £325m, so LLR has received a large share.

4.5 This investment will be split between ourselves (£30m) and Leicestershire Partnership Trust (£8m) allowing us to invest in:

- an increase of 11 beds in Adult Level 3 capacity at Glenfield, crucial in enabling the transfer of clinical activities reliant on Adult Level 3 care from the General Hospital;

- additional refurbished bed capacity at Glenfield and the Royal Infirmary (crucial to balancing demand and capacity);
- the provision of a new ward block at Glenfield (as above);
- the provision of interventional radiology capacity at Glenfield to support the Intensive Care Unit dependent services moving there;
- LPT will be able to create a build a new purpose-built unit for 15-bed combined child and adolescent mental health services which will include a new CAMHS service and eating disorder services (CAEDS) inpatient facility at Glenfield.

4.6 I am delighted, as this funding is a vote of confidence in our plans for the future development of Leicester's hospitals and fully funds the next schemes in those plans. Following the opening of our fantastic new Emergency Department at the Royal Infirmary in April and new state of the art facilities for vascular surgery at Glenfield in May, this latest investment will deliver yet more new facilities for our patients. This gives me great optimism that we will be able to deliver our complete plans over the next few years to focus all emergency and specialist care at the Royal and Glenfield, with a different future for the General providing fewer acute health care services.

4.7 This immediate funding can be seen as a “down payment” on our longer terms plans, as the Government has committed to a much larger NHS capital investment programme later this year. We have already bid for a total of £397.5m against that programme. Together with our own capital funds, if this further bid is successful (and subject to public consultation) it will allow us to carry out our whole reconfiguration programme. The key components of this are shown in the table below (note that this list is not exhaustive):

Leicester Royal Infirmary	Glenfield Hospital
Women’s Hospital	Planned Ambulatory Care Hub
Enhanced ICU facilities	Enhanced ICU facilities (now funded)
Increased bed base – new build & refurbishment	Increased bed base – new build (part funded)
Welcome Centre (to be commercially funded)	Extension to Clinical Decisions Unit
Children’s Hospital (EMCHC move inc new PICU now funded)	Interventional radiology (now funded)
Infrastructure	Infrastructure
	New build theatres

4.8 In addition, we may provide a stand-alone Birth Centre at the General Hospital dependant on the outcome of consultation and we will re-provide our Stroke and Neuro Rehab Unit either at the General or in a community location.

Leicester, Leicestershire and Rutland Sustainability and Transformation Partnership

4.9 The Boards of the LLR NHS organisations recently held a joint session to take stock of progress with Better Care Together, which forms of local Sustainability and

Transformation plan. This was a positive session with a good consensus about the key next steps in our journey to provide a more effective, integrated and sustainable service to patients and service users.

4.10 The key next steps identified included:

- Introducing new "terms of trade" which better align financial incentives with system goals
- Balancing the books over the medium term – this is a challenge given forecast NHS resources
- Publishing an updated BCT plan – planned for September
- Going out to formal public consultation on acute and community reconfiguration plans – planned for February 2018
- Developing an Accountable Care System

5. Conclusion

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

John Adler
Chief Executive

27th July 2017

Quality & Performance

		YTD Plan	YTD Actual	Jun-17 Plan	Jun-17 Actual	Trend*	Compliant by?
Safe	**S1: Reduction for moderate harm and above (1 month in arrears)**	142	31	<12	20	●	Jul-17
	S2: Serious Incidents	<37	11	3	2	●	
	S10: Never events	0	3	0	0	●	
	S11: Clostridium Difficile	61	15	5	10	●	
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	0	0	0	●	
	S13: MRSA (Avoidable)	0	0	0	0	●	
	S14: MRSA (All)	0	0	0	0	●	
	S17: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	5.7	<5.6	5.4	●	
	S18: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●	
	S19: Avoidable Pressure Ulcers Grade 3	<27	5	<=3	5	●	
	S20: Avoidable Pressure Ulcers Grade 2	<84	13	<=7	2	●	
Caring	**C1 End of Life Care Plans**	TBC	QC TBC		QC TBC		
	C4: Inpatient and Day Case friends & family - % positive	97%	97%	97%	97%	●	
	C7: A&E friends and family - % positive	97%	94%	97%	96%	●	
Well Led	W13: % of Staff with Annual Appraisal	95%	92.1%	95%	92.1%	●	
	W14: Statutory and Mandatory Training	95%	82%	95%	82%	●	
	W16 BME % - Leadership (8A – Including Medical Consultants) - Qtr 1	28%	26%	28%	26%		
	W17: BME % - Leadership (8A – Excluding Medical Consultants) - Qtr 1	28%	12%	28%	12%		
Effective	**E1: 30 day readmissions (1 month in arrears)**	<8.5%	9.2%	<8.5%	8.9%	●	Sep-17
	E2: Mortality Published SHMI (Jan16-Dec 16)	99	101	99	101	●	
	E6: # Neck Femurs operated on 0-35hrs	72%	66.8%	72%	76.8%	●	
	E8: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	86.4%	80%	85.7%	●	
Responsive	R1: ED 4hr Waits UHL+UCC - Calendar Month	95%	78.3%	95%	77.6%	●	See Note 1
	R3: RTT waiting Times - Incompletes (UHL+Alliance)	92%	92.3%	92%	92.3%	●	
	R5: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	0.7%	<1%	0.7%	●	
	R11: Operations cancelled (UHL + Alliance)	0.8%	1.0%	0.8%	1.0%	●	See Note 1
	R13: Delayed transfers of care	3.5%	1.8%	3.5%	1.4%	●	
	R14: % Ambulance Handover >60 Mins (CAD+)	TBC	5%	TBC	2%	●	TBC
	R15: % Ambulance handover >30mins & <60mins (CAD+)	TBC	11%	TBC	8%	●	TBC
	RC9: Cancer waiting 104+ days	0	12	0	12	●	

		YTD Plan	YTD Actual	May-17 Plan	May-17 Actual	Trend*	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	94.4%	93%	95.4%	●	
	RC3: 31 day target - All Cancers	96%	95.3%	96%	94.6%	●	See Note 1
	RC7: 62 day target - All Cancers	85%	79.9%	85%	76.6%	●	See Note 1

Enablers

		YTD Plan	YTD Actual	Qtr1 17/18 Plan	Qtr1 17/18 Actual
People	W7: Staff recommend as a place to work (from Pulse Check)		62.5%		62.5%
	C10: Staff recommend as a place for treatment (from Pulse Check)		74.3%		74.3%

		YTD Plan	YTD Actual	Jun-17 Plan	Jun-17 Actual	Trend*
Finance	Surplus/(deficit) £m	(17.6)	(17.6)	(4.0)	(4.0)	●
	Cashflow balance (as a measure of liquidity) £m	1.0	3.8	1.0	3.8	●
	CIP £m	6.3	7.4	3.0	3.8	●
	Capex £m	6.4	6.9	2.6	3.2	●

		YTD Plan	YTD Actual	Jun-17 Plan	Jun-17 Actual	Trend*
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	96%	98%	96%	●
	Average cleanliness audit score -high risk areas	95%	94%	95%	94%	●
	Average cleanliness audit score - significant risk areas	85%	94%	85%	94%	●

* 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 - **'Compliant by?'** for these metrics a are dependent on the Trust rebalancing demand and capacity.

UHL Board Assurance Dashboard: 2017/18

JUNE 2017

	Objective	Annual Priority No.	Annual Priority	Exec Owner	SRO	Current Assurance Rating	Monthly Tracker	Year-end Forecast Assurance Rating	Executive Board Committee for Endorsement	Trust Board / Sub-Committee for Assurance
Primary Objective	**QUALITY COMMITMENT:** Safe, high quality, patient centered, efficient healthcare	1.1	**Clinical Effectiveness - To reduce avoidable deaths:**							
		1.1.1	We will focus interventions in conditions with a higher than expected mortality rate in order to reduce our SHMI	MD	J Jameson (R Broughton)	4	↔	4	EQB	QAC
		1.2	**Patient Safety - To reduce harm caused by unwarranted clinical variation:**							
		1.2.1	We will further roll-out track and trigger tools (e.g. sepsis care), in order to improve our vigilance and management of deteriorating patients	CN/MD	J Jameson (H Harrison)	3	↔	4	EQB	QAC
		1.2.2	We will introduce safer use of high risk drugs (e.g. insulin and warfarin) in order to protect our patients from harm	MD/CN	E Meldrum / C Free & C Marshall	2	↓	3	EQB	QAC
		1.2.3	We will implement processes to improve diagnostics results management in order to ensure that results are promptly acted upon	MD	C Marshall	3	↔	3	EQB	QAC
		1.3	**Patient Experience - To use patient feedback to drive improvements to services an care:**							
		1.3.1	We will provide individualised end of life care plans for patients in their last days of life (5 priorities of the Dying Person) in that our care reflects our patients' wishes	CN	S Hotson (C Ribbins) (H Harrison)	3	↔	4	EQB	QAC
		1.3.2	We will improve the patient experience in our current outpatients service and begin work to transform our outpatient models of care in order to make them more effective and sustainable in the longer term	DCIE / COO	J Edyvean / D Mitchell	3	↔	3	EPB	IFPIC
		1.4	**Organisation of Care - We will manage our demand and capacity:**							
		1.4.1	We will utilise our new Emergency Department efficiently and effectively We will use our bed capacity efficiently and effectively (including Red2Green, SAFER, expanding bed capacity) We will implement new step down capacity and a new front door frailty pathway We will use our theatres efficiently and effectively	COO	S Barton	3	↔	4	EPB	IFPIC
Supporting Objectives	**OUR PEOPLE:** Right people with the right skills in the right numbers	2.1	We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care	DWOD	J Tyler-Fantom	4	↔	3	EWB	IFPIC
		2.2	We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget	DWOD	J Tyler-Fantom	4	↔	3	EPB	IFPIC
		2.3	We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'	DWOD	B Kotecha	4	↑	4	EWB	IFPIC
	EDUCATION & RESEARCH: High quality, relevant, education and research	3.1	We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education	MD	S Carr	3	↔	4	EWB	TB
		3.2	We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates	MD	S Carr	3	↔	4	EWB	TB
		3.3	We will develop a new 5-Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership	MD	N Brunskill	4	↔	4	ESB	TB
	PARTNERSHIPS & INTEGRATION: More integrated care in partnership with others	4.1	We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty	DCIE	G Distefano	3	↔	3	ESB	TB
		4.2	We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals	DCIE	G Distefano	3	↔	3	ESB	TB
		4.3	We will form new relationships with primary care in order to enhance our joint working and improve its sustainability	DCIE	J Currington (U Montgomery)	3	↔	3	ESB	TB
	KEY STRATEGIC ENABLERS: Progress our key strategic enablers	5.1	We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work	CFO	N Topham (A Fawcett)	3	↔	3	ESB	TB
		5.2	We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care	CIO	J Clarke	4	↔	3	EIM&T	IFPIC
		5.3	We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services	DWOD	B Kotecha	4	↑	4	EWB	IFPIC
		5.4	We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities	DWOD/CFO	L Tibbert (J Lewin)	3	↔	3	EWB	IFPIC
		5.5	We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust	CFO	P Traynor	4	↔	4	EPB	IFPIC
		5.6	We will deliver our Cost Improvement and Financial plans in order to make the Trust clinically and financially sustainable in the long term	CFO/COO	P Traynor (B Shaw)	4	↔	3	EPB	IFPIC

Risk Register dashboard as at end of June 2017

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Subtype	Thematic Analysis of Risk Causation
2236	ESM	There is a risk of overcrowding due to the design and size of the ED footprint & increased attendance to ED	25	16	Dr Ian Lawrence	↔	Harm	Demand and Capacity
2264	CHUGGS	If an effective solution for the staffing shortages in GI Medicine Surgery and Urology at LGH and LRI is not found, then the safety and quality of care provided will be adversely impacted.	20 ↑	6	Georgina Kenney	↑	Harm	Workforce
2621	CHUGGS	There is a risk to patient safety & quality due to poor skill mix on Ward 22, LRI	20 ↑	6	Kerry Johnston	↑	Harm	Workforce
2566	CHUGGS	If the range of Toshiba Aquilion CT scanners are not upgraded, Then patients will experience delays with their treatment planning process.	20	1	Lorraine Williams	↔	Harm	Equipment
2354	RRCV	If the capacity of the Clinical Decisions Unit is not expanded to meet the increase in demand, then will continue to experience overcrowding resulting in potential harm to patients.	20	9	Sue Mason	↔	Harm	Demand and Capacity
2670	RRCV	If recruitment to the Clinical Immunology & Allergy Service Consultant vacancy does not occur, then patient backlog will continue to increase, resulting in delayed patient sequential procedures and patient management.	20	6	Karen Jones	↔	Harm	Workforce
2886	RRCV	If we do not invest in the replacement of the Water Treatment Plant at LGH, Then we may experience downtime from equipment failure impacting on clinical treatment offered.	20	8	Geraldine Ward	↔	Service Disruption	Estates
2931	RRCV	If the failing Cardiac Monitoring Systems in CCU are not replaced, Then we will not be able safely admit critically unwell, unstable persons through EMAS with, STEMI,NSTEMI, OoHCA and Errhythmais.	20	4	Judy Gilmore	↔	Harm	Equipment
3040	RRCV	If there are insufficient medical trainees in Cardiology, we may experience an imbalance between service and education demands resulting in the inability to cover rota	20	9	Darren Turner	NEW	Service Disruption	Workforce
2804	ESM	If the ongoing pressures in medical admissions continue, then ESM CMG medicine bed base will be insufficient thus resulting in jeopardised delivery of RTT targets.	20	12	Susan Burton	↔	Harm	Demand and Capacity
2149	ESM	If we do not recruit and retain into the current Nursing vacancies within ESM, then patient safety and quality of care will be compromised thus resulting in potential financial penalties.	20	6	Susan Burton	↔	Harm	Workforce
2763	ITAPS	Risk of patient deterioration due to the cancellation of elective surgery as a result of lack of ICU capacity at LRI	20	10	Chris Allsager	↔	Harm	Demand and Capacity
2990	MSK & SS	There is a risk of delayed outpatient corrospondance to referer/patient following clinic attendance.	20	3	Clare Rose	↔	Harm	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Subtype	Thematic Analysis of Risk Causation
2191	MSK & SS	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	20	8	Clare Rose	⟷	Harm	Demand and Capacity
2867	CSI	If the Mortuary flooring is not repaired, then we will continue to breach Department of Health Building note 20 and the HSAC (Health Services Advisory Committee) advice by exposing staff to harm.	20	3	Anne Freestone	⟷	Harm	Estates
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	Nicola Savage	⟷	Finance	Demand and Capacity
2403	Corporate Nursing	There is a risk changes in the organisational structure will adversely affect water management arrangements in UHL	20	4	Elizabeth Collins	⟷	Harm	Estates
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	⟷	Harm	Equipment
2471	CHUGGS	If the Trust does not invest in upgrading our aged imaging equipment, then we will continue to breach national guidance and Radiotherapy Services specification of 10 years replacement recommendations	16	4	**CLOSED**		Harm	Equipment
2820	RRCV	If a timely VTE risk assessments is not undertaken on admission to CDU, then we will be breach of NICE CCG92 guidelines resulting patients being placed at risk of harm.	16	3	Karen Jones	⟷	Harm	Processes and Procedures
3031	RRCV	If the MDT activities for vasc surg are not resolved there is a risk of signif loss of income & activity from referring centres	16	1	Martin Watts	**NEW**	Harm	Equipment
3044	ESM	If under achievement against key CQUIN Triggers, Then income will be affected.	16	1	Elaine Graves	**NEW**	Finance	Demand and Capacity
2333	ITAPS	If we do not recruit into the Paediatric Cardiac Anaesthetic vacancies, then we will not be able to maintain a WTD compliant rota resulting in service disruption.	16	8	Chris Allsager	⟷	Service Disruption	Workforce
2193	ITAPS	If an effective maintenance schedule for Theatres and Recovery plants is not put in place, then we are prone to unplanned loss of capacity at the LRI.	16	4	Gaby Harris	⟷	Service Disruption	Estates
2955	CSI	If system faults attributed to EMRAD are not expediently resolved, Then we will continue to expose patient to the risk of harm	16	4	Cathy Lea	⟷	Harm	IM&T
1206	CSI	If the backlog of unreported Chest and Abdomen images on PAC'S are not cleared, then we will breach IRMER and Royal College of Radiologist guidelines.	12 ↓	6	ARI	↓	Harm	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Subtype	Thematic Analysis of Risk Causation
2378	CSI	If we do not recruit, up skill and retain staff into the Pharmacy workforce, then the service will not meet increasing demands resulting in reduced staff presence on wards or clinics.	16	8	Claire Ellwood	⟷	Service Disruption	Workforce
2916	CSI	There is a risk that patient blood samples can be mislabelled impacting on patient safety	16	6	Debbie Waters	↑	Harm	IM&T
2391	W&C	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	8	Ms Cornelia Wiesender	⟷	Harm	Workforce
2153	W&C	Shortfall in the number of all qualified nurses working in the Children's Hospital.	16	8	Ms Hilliary Killer	⟷	Harm	Workforce
3008	W&C	If the paediatric retrieval and repatriation teams are delayed mobilising to critically ill children due to inadequately commissioned & funded provision of a dedicated ambulance service, then this will result in failure to meet NHS England standards, delayed care, potential harm and inability to free-up PICU capacity.	16	5	Andrew Leslie	⟷	Harm	Demand and Capacity
2237	Corporate Medical	If a standardised process for requesting and reporting inpatient and outpatient diagnostic tests is not implemented, then the timely review of diagnostic tests will not occur.	16	8	Colette Marshall	⟷	Harm	IM&T
2247	Corporate Nursing	If we do not recruit and retain Registered Nurses, then we may not be able to deliver safe, high quality, patient centred and effective care.	16	12	Maria McAuley	⟷	Harm	Workforce
1693	Operations	If clinical coding is not accurate then income will be affected.	16	8	Shirley Priestnall	⟷	Finance	Workforce
3041	RRCV	If there are insufficient cardiac physiologists then it could result in increased waiting times for electrophysiology procedures and elective cardiology procedures	15	8	Darren Turner	**NEW**	Harm	Workforce
3043	RRCV	If there is insufficient cardiac physiologists then it could result in reduced echo capacity resulting in diagnostics not being performed in a timely manner	15	6	Darren Turner	**NEW**	Harm	Workforce
2872	RRCV	If a suitable fire evacuation route for bariatric patients on Ward 15 at GGH is not found, then we will be in breach of Section 14.2b of The Regulatory Reform (Fire Order) 2005.	15	6	Vicky Osborne	⟷	Harm	Estates
3005	RRCV	If recruitment and retention to the current Thoracic Surgery Ward RN vacancies does not occur, then Ward functionality will be compromise, resulting in an increased likelihood of incidences leading to patient harm.	15	6	Sue Mason	⟷	Harm	Workforce
2837	ESM	If the migration to a automated results monitoring system does not take place, Then follow-up actions for patients with multiple sclerosis maybe delayed.	15	2	Dr Ian Lawrence	⟷	Harm	IM&T

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Subtype	Thematic Analysis of Risk Causation
2989	MSK & SS	If we do not recruit into the Trauma Wards nursing vacancies, then patient safety and quality of care will be placed at risk	15	4	Nicola Grant	⟷	Harm	Workforce
1196	CSI	If we do not increase the number of Consultant Radiologists, then we will not be able provide a comprehensive out of hours on call rota and PM cover for consultant Paediatric radiologists resulting in delays for patients requiring paediatric radiology investigations and suboptimal treatment pathway.	15	2	Miss Rona Gidlow	⟷	Harm	Workforce
2946	CSI	If the service delivery model for Head and Neck Cancer patients is not appropriately resourced, then the Trust will be non-compliant with Cancer peer review standards resulting in poor pre and post-surgery malnutrition.	15	2	Cathy Steele	⟷	Harm	Workforce
2973	CSI	If the service delivery model for Adult Gastroenterology Medicine patients is not appropriately resourced, then the quality of care provided by nutrition and dietetic service will be suboptimal resulting in potential harm to patients.	15	6	Cathy Steele	⟷	Harm	Workforce
2787	CSI	If we do not implement the EDRM project across UHL which has caused wide scale recruitment and retention issues then medical records services will continue to provide a suboptimal service which will impact on the patients treatment pathway.	15	4	Debbie Waters	⟷	Harm	IM&T
2965	CSI	If we do not address Windsor pharmacy storage demands, then we may compromise clinical care and breach statutory duties	15	6	Claire Ellwood	⟷	Harm	Estates
3023	W&C	There is a risk that the split site Maternity configuration leads to impaired quality of Maternity services at the LGH site	15	6	Ms Cornelia Wiesender	**NEW**	Harm	Workforce
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	DMAR	⟷	Harm	Workforce
2394	Communications	If a service agreement to support the image storage software used for Clinical Photography is not in place, then we will not be able access clinical images in the event of a system failure.	15	1	Simon Andrews	⟷	Harm	IM&T
2402	Corporate Nursing	There is a risk that inappropriate decontamination practice my result in harm to patients and staff	15	3	**CLOSED**		Harm	Equipment
2985	Corporate Nursing	If the delays with supplying, delivering and administrating parental nutrition at ward level are not resolved, then we will deliver a suboptimal and unsafe provision of adult inpatient parental nutrition resulting in the Trust HISNET Status.	15	4	Cathy Steele	⟷	Harm	Workforce