CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – OCTOBER 2017

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 October 2017 is attached. It includes:-

(a) the Quality and Performance Dashboard for August 2017 attached at appendix 1 (the full month 5 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: [2 November 2017 Trust Board]

6. Executive Summaries should not exceed 2 **pages**. [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: **5 OCTOBER 2017**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – OCTOBER 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 – August 2017

2.1 The Quality and Performance Dashboard for August 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 5 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. **Diagnostic 6 week wait –** remains compliant for the 11th consecutive month. **52+ week waits –** current number this month is 18 patients (last August the number was 57). **Cancer Two Week Wait** – have achieved the 93% threshold for over a year. **Cancer 31 day** was achieved in August. **Delayed transfers of care** - remain within the tolerance.

However, there are a range of other delays that do not appear in the count. **Pressure Ulcers** – Zero **Grade 4** pressure ulcers reported this financial year. **Grade 3 and Grade 2** are well within the trajectory year to date with only 1 **Grade 2** reported in August. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured NOF** – achieved for the last 4 months. **Ambulance Handover 60+ minutes (CAD+)** – performance at 2% a slight increase of 1% from July, nevertheless a significant improvement and one of our best performances since the introduction of CAD+ reporting in June 2015. **Single Sex Accommodation Breaches** – 0 breaches in August.

Bad News:

2.5 **Moderate harms and above** – although the number of cases reported during July (reported 1 month in arrears) was within trajectory, the year to date is above threshold. **Never events** – 1 reported this month, further detail is included in the Quality and Performance report. **MRSA** – one unavoidable case reported this month. **C DIFF -** August and year to date are above threshold. **ED 4 hour performance** – August's performance was 83.2%, a improvement on April to July. Further detail is in the Chief Operating Officer's report. **Referral to Treatment –** was 91.8% against a target of 92%, partly due to cancelled operations. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant. **Cancer 62 day treatment** was not achieved in July – delayed referrals from network hospitals continue to be a significant factor. **Statutory & Mandatory Training** – 85% against a target of 95%. **TIA (high risk patients)** was non-compliant in August due to increase in Clinical Commissioning Group referrals.

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

3.1 The Board Assurance Framework (BAF) and organisational risk register have been kept under review during August 2017 and are summarised in the two 'dashboards' attached to this report. A detailed BAF and an extract from the risk register, for items scoring 15 and above, are included in the integrated risk and assurance paper which features elsewhere on this Board agenda.

Board Assurance Framework Dashboard

3.2 Executive leads have updated their entries in the BAF to reflect the current position for August 2017. Key risk themes identified on the BAF relate to workforce, IT systems, finances, and demand and capacity imbalance.

3.3 The corporate risk team have undertaken a mid-year review of the BAF, along with listening to feedback from recent Board and Committee meetings and will be making some improvements to the framework to make the principal risks more visible in the document. This review was approved by the Executive Performance Board at its September meeting and will be worked-up with Executive and Corporate Directors and their teams during October and an updated BAF will be presented to the Trust Board in November 2017.

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 or extreme) for the reporting period ending August 2017. During the month of August 2017,three high risks have been entered on the risk register, including two new entries and one escalated from a moderate rating.

3.5 Thematic analysis of the risks scoring 15 and above on the risk register shows that the main cause is related to challenges with workforce capacity and capability, with the typical impact relating to potential harm.

4 Emergency Care

4.1 At its meeting on 28th September 2017, the newly-established People, Process and Performance Committee considered our emergency care performance and we discussed the actions in hand, and planned, to bring about improvements. Whilst not wishing to duplicate the Committee's discussions, I am bound to say that our performance against the national 4 hour standard remains poor, notwithstanding our improvements since July.

4.2 We are currently building on the 'September Surge' actions to better align demand and capacity in ED, make changes to acute medical working arrangements working arrangements; strengthen specialty ownership of patients in ED and AMU; accelerate bed allocation and movement; and implement a new approach to the 'Silver Command' tier.

4.3 In order to drive more rapid improvement, and to make more fundamental changes than has hitherto been the case, I have introduced a new more intensive approach involving daily action meetings. As a result I am giving considerable personal focus to this issue, with the inevitable impact on other areas of portfolio.

5 East Midlands Congenital Heart Centre

5.1 We had hoped that NHS England would take a final decision on the outcome of their review of congenital heart surgery at their Board meeting on 28th September. Unfortunately, on 20th September NHS England advised us that they are awaiting confirmation of some information supplied by Provider Trusts before a final recommendation can be put to their public Board meeting and that, consequently, a decision will be made at their public Board meeting on 30th November.

5.2 This further delay is of course frustrating and will cause further anxiety to patients, their families and our staff. However, we do at least now appear to have a firm commitment to a timescale for decision.

5.3 Further details are set out in the report on the East Midlands Congenital Heart Centre which features later in this agenda.

6. Conclusion

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

John Adler
Chief Executive

29th September 2017

Quality & Performance

		YTD Plan	YTD Actual	Aug-17 Plan	Aug-17 Actual	Trend*	Compliant by?
Safe	**S1: Reduction for moderate harm and above (1 month in arrears)**	142	68	<12	12	●	
	S2: Serious Incidents	<37	20	3	3	●	
	S10: Never events	0	4	0	1	●	Sep-17
	S11: Clostridium Difficile	61	27	5	7	●	Sep-17
	S12 MRSA - Unavoidable or Assigned to 3rd party	0	1	0	1	●	Sep-17
	S13: MRSA (Avoidable)	0	0	0	0	●	
	S14: MRSA (All)	0	1	0	1	●	Sep-17
	S17: Falls per 1,000 bed days for patients > 65 years (1 month in arrears)	<5.6	5.4	<5.6	4.6	●	
	S18: Avoidable Pressure Ulcers Grade 4	0	0	0	0	●	
	S19: Avoidable Pressure Ulcers Grade 3	<27	5	<=3	0	●	
	S20: Avoidable Pressure Ulcers Grade 2	<84	18	<=7	1	●	
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%	95%	97%	98%	●	
Well Led	W13: % of Staff with Annual Appraisal	95%	91.2%	95%	91.2%	●	
	W14: Statutory and Mandatory Training (July)	95%	85%	95%	85%		
	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%	9.1%	<8.5%	8.9%	●	Oct-17
	E2: Mortality Published SHMI (Jan16-Dec 16)	99	101	99	101	●	
	E6: # Neck Femurs operated on 0-35hrs	72%	71.4%	72%	80.6%	●	
	E8: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	87.8%	80%	92.6%	●	
Responsive	R1: ED 4hr Waits UHL+UCC - Calendar Month	95%	79.5%	95%	83.2%	●	See Note 1
	R3: RTT waiting Times - Incompletes (UHL+Alliance)	92%	91.9%	92%	91.8%	●	
	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%	1.1%	●	See Note 1
	R13: Delayed transfers of care	3.5%	1.8%	3.5%	1.7%	●	
	R14: % Ambulance Handover >60 Mins (CAD+)	TBC	3%	TBC	2%	●	
	R15: % Ambulance handover >30mins & <60mins (CAD+)	TBC	9%	TBC	4%	●	
	RC9: Cancer waiting 104+ days	0	6	0	6	●	

		YTD Plan	YTD Actual	Jul-17 Plan	Jul-17 Actual	Trend*	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	94.4%	93%	93.7%	●	
	RC3: 31 day target - All Cancers	96%	96.1%	96%	96.2%	●	
	RC7: 62 day target - All Cancers	85%	79.9%	85%	82.1%	●	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	Aug-17 Plan	Aug-17 Actual	Trend*
Finance	Surplus/(deficit) £m	(22.9)	(22.9)	(2.0)	(2.0)	●
	Cashflow balance (as a measure of liquidity) £m	1.0	3.1	1.0	3.1	●
	CIP £m	13.1	13.1	2.9	2.3	●
	Capex £m	11.4	10.5	2.7	1.5	●

		YTD Plan	YTD Actual	Aug-17 Plan	Aug-17 Actual	Trend*
Estates & facility mgt.	Average cleanliness audit score - very high risk areas	98%	97%	98%	96%	●
	Average cleanliness audit score -high risk areas	95%	94%	95%	94%	●
	Average cleanliness audit score - significant risk areas	85%	94%	85%	93%	●

* 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			AUG 2017 - FINAL								
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 a	We will introduce safer use of high risk drugs **(e.g. insulin)** in order to protect our patients from harm	MD/CN	E Meldrum / C Free	2	↔	3	EQB	QAC
		1.2.2 b	We will introduce safer use of high risk drugs **(e.g. warfarin)** in order to protect our patients from harm	MD/CN	C Marshall	3	↔	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	2	↔	2	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	EQB	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	2	↓	2	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	J Currington	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	J Currington	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	↓	2	EPB	IFPIC

UHL Risk Register Dashboard as at 31 August 2017

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Thematic Analysis of Risk Subtype	Thematic Analysis of Risk Causation
2264	CHUGGS	If an effective solution for the nurse 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	Harm	Workforce
2621	CHUGGS	If recruitment and retention to vacancies on Ward 22 at the LRI does not occur, then patients may be exposed to harm due to poor skill mix on the Ward.	20	6	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	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	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	Service disruption	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	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	Harm	Equipment
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	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 resulting in potential financial penalties.	20	6	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	Harm	Demand and Capacity
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.	20	4	Service disruption	Estates
2191	MSK	Lack of capacity within the ophthalmology service is causing delays that could result in serious patient harm.	20	8	Harm	Demand and Capacity
2940	W&C	Risk that paed cardiac surgery will cease to be commissioned in Leicester with consequences for intensive care & other services	20	8	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	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	Harm	Equipment
3040	RRCV	If there are insufficient medical trainees in Cardiology, then there may be an imbalance between service and education demands resulting in the inability to cover rotas and deliver safe, high quality patient care.	16 ↓	9	Service disruption	Workforce
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	Harm	Processes and Procedures
3051	RRCV	If we do not effectively recruit to the Medical Staffing gaps for Respiratory Services, then there is a risk to deliver safe, high quality patient care, operational services and impacts on the wellbeing of all staff including medical staffing.	16	6	Service disruption	Workforce
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	Service disruption	Equipment
3025	ESM	If there continues to be high levels of nursing vacancies and issue with nursing skill mix across Emergency Medicine, then quality and safety of patient care could be compromised.	16	4	Harm	Workforce
3044	ESM	If under achievement against key Infectious Disease CQUIN Triggers (Hepatitis C Virus), then income will be affected.	16	12	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	Service disruption	Workforce

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	Harm	IM&T
2673	CSI	If the bid for the National Genetics reconfiguration is not successful then there will be a financial risk to the Trust resulting in the loss of the Cytogenetics service	16 ↑	8	Finance	Demand and Capacity
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	Service disruption	Workforce
2916	CSI	There is a risk that patient blood samples can be mislabelled impacting on patient safety	16	6	Harm	IM&T
2391	W&C	Inadequate numbers of Junior Doctors to support the clinical services within Gynaecology & Obstetrics	16	8	Harm	Workforce
2153	W&C	Shortfall in the number of all quallfied nurses working in the Children's Hospital.	16	8	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	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	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	Harm	Workforce
1693	Operations	If clinical coding is not accurate then income will be affected.	16	8	Finance	Workforce
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	15	4	Harm	Workforce
3047	RRCV	If the service provisions for vascular access at GH are not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Harm	Demand and Capacity
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	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	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	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	Harm	Workforce
3077	ESM	If there are delays in the availability of in-patient beds, then the performance of the Emergency Department at Leicester Royal Infirmary could be adversely affected, resulting in overcrowding in the Emergency Department and an inability to accept new patients from ambulances.	15	10	Harm	Demand and Capacity
2837	ESM	If the migration to an automated results monitoring system is not introduced, then follow-up actions for patients with multiple sclerosis maybe delayed resulting in potential harm.	15	2	Harm	IM&T
2466	ESM	Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting >	15	1	Harm	Processes and Procedures
2989	MSK	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	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	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	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	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	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	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	Harm	Workforce
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	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	Harm	IM&T
3079	Corporate Medical	If the insufficient capacity with Medical Examiners is not addressed then this may lead to a delay with screening all deaths and undertaking Structured Judgement Reviews resulting in failure to learn from deaths in a timely manner and non-compliance with the internal QC and external NHS England duties	15	6	Reputation	Workforce
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	Harm	Workforce