CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – SEPTEMBER 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 September 2017 is attached. It includes:-

(a)   the Quality and Performance Dashboard for July 2017 attached at appendix 1 (the full month 4 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: [5.10.17 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: 7 SEPTEMBER 2017

REPORT BY: CHIEF EXECUTIVE

SUBJECT: MONTHLY UPDATE REPORT – SEPTEMBER 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 – July 2017

2.1   The Quality and Performance Dashboard for July 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 4 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 10th consecutive month. **52+ week waits** – current number this month is 16 patients (last July the number was 77). **Cancer Two Week Wait** – have achieved the 93% threshold for 12 months running. **Cancer 31 day** was achieved in June and cumulatively for Quarter 1. **Delayed 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 4 months. **C DIFF** July and year to date remain within threshold. **Pressure Ulcers** – Zero **Grade 4** pressure ulcers reported this financial year, **Grade 3 and Grade 2** are well within the trajectory year to date. **CAS alerts** – we remain compliant. **Inpatient and Day Case Patient Satisfaction (FFT)** achieved the Quality Commitment of 97%. **Fractured NOF** – was achieved for the last 3 months. **Ambulance Handover 60+ minutes (CAD+)** – performance at 1% is a significant improvement – this is by far the best performance since the introduction of CAD+ reporting in June 2015. **TIA (high risk patients)** remains compliant following a couple of months of non-compliance.

Bad News:

2.5   **Moderate harms and above** – 18 cases reported during June (reported 1 month in arrears) and above threshold for year to date. This requires further investigation. **ED 4 hour performance** – July's performance was 79.8%, a small improvement on May and June.   August performance to 24/8 is 85.2%. Further detail is in the Chief Operating Officer's report. **Referral to Treatment –** was 91.8% against a target of 92% due to high level of referrals in March 17 and cancelled operations. **Cancelled operations** and **patients rebooked within 28 days** – continued to be non-compliant. **Cancer 62 day treatment** was not achieved in June – delayed referrals from network hospitals are now a significant factor. **Single Sex Accommodation Breaches** – 2 breaches during July. **Statutory & Mandatory Training** – 85% against a target of 95%.

3   Board Assurance Framework (BAF) and Organisational Risk Register Dashboards

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 July 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   Thematic analysis of the risks recorded on the BAF, associated with delivering our quality commitment, continues to show there is reliance upon safe implementation of appropriate electronic observation systems and processes. Other key risk themes identified on the BAF are related to finance, workforce and demand and capacity.

3.5 The BAF will continue to be reviewed by executive leads and scrutinised by the Executive Team to monitor assurances and progress with managing the principal risks that threaten delivering the Trust's annual priorities.

Organisational Risk Register

3.6 There are currently 49 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 July 2017. During the month of July 2017 four high risks have been entered on the risk register, including three new entries and one escalated from a moderate rating.

3.7 Thematic analysis of the risks scoring 15 and above on the risk register shows that the main cause is related to challenges with workforce, in particular around capacity and capability, with the typical impact described as potential harm.

3.8 In line with the reporting arrangements described in the risk management policy, a copy of the organisational 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 Board agenda.

4 Quarterly review meeting with NHS Improvement – 12 July 2017

4.1 A number of Board members, including the Chairman and myself, met with NHS Improvement representatives on 12 July 2017. A copy of the letter received on 31 July 2017 from Mr D Bywater, Executive Regional Managing Director, Midlands and East, summarising the meeting is attached **at Appendix 4**.

4.2 The Trust has since responded to the issues identified at the end of the letter under "Next Steps" and the position is as follows:

a. Update on data, demand and capacity (including an increase in Emergency Department "Direct Clinical Care") and

b. Perfect week/month in urgent care services

Further information on these matters is set out in the Chief Operating Officer's report featuring elsewhere on this agenda.

c. Review of Cost Improvement Programme (CIP) plans and revised CIP target 2017/18

As discussed recently at the Integrated Finance, Performance and Investment Committee, we need to identify additional savings – additional to the existing Cost Improvement Programme (CIP) of £33m – to remain on budget in 2017/18 and to fund the additional capacity we need for Winter 2017.

The CIP has been increased by £3.5m in 2017/18 and £7m recurrently. We will be looking to make these changes intelligently by changing the way we are working and not recruiting to some of the vacancies we currently hold.

Clinical Management Groups and Corporate Directorates are working to identify how they will contribute to this requirement and the position will continue to be monitored by the Integrated Finance, Performance and Investment Committee. Progress to date has been good and there is a deadline of 30th September in place to finalise these plans.

d. <u>NHS Improvement to undertake a detailed review of the Trust's "structural deficit"</u>

The results of this review will be shared with the Trust and reported to the Integrated Finance, Performance and Investment Committee. This issue relates to the extra costs associated with operating across three acute sites. As Board members are aware the strategic direction of the Trust is to focus intensive-care and dependent services on two sites for reasons of both clinical and financial sustainability/

e. <u>Long-standing locums – transfer to Trust payroll</u>

Work in this regard is well advanced and is being coordinated by the Director of Workforce and Organisational Development. As will be seen in the Finance report, spending on agency and locum staff is currently within the cap set by NHs Improvement.

f. <u>Further meeting between the Chairman, Chief Executive and Executive Regional Managing Director, NHS Improvement</u>

This meeting has been arranged for late October.

4.3 I will update the Board verbally on any further developments, but it is also worth noting that a number of Board members (including Col (Ret'd) Ian Crowe, Non Executive Director and Quality Assurance Committee Chair) and I met with representatives of the LLR Clinical Commissioning Groups on 18 July 2017 to discuss the quality concerns mentioned in the "Quality" section of the letter attached at Appendix 4.

4.4 The meeting was constructive and a small number of joint actions were agreed, progress against which will be reported to the Executive Quality Board and Quality Assurance Committee. These focused on improving communication between primary and secondary care and better joint working around clinical incident follow-up.

5 <u>Moving Towards Accountable Care in Leicester, Leicestershire and Rutland</u>

5.1 The System Leadership Team has held discussions on the development of an Accountable Care System in Leicester, Leicestershire and Rutland.

5.2 A paper setting out proposals on the development of such a System features elsewhere on this Board agenda.

5.3   Taking into account any initial comments on the proposal which Board members may wish to make at today's meeting, the intention is for the Board to discuss the paper in detail at its September Thinking Day.

5.4   I will continue to keep the Board updated on developments on this subject.

6   East Midlands Congenital Heart Centre

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

6.2   As noted in that report, NHS England has confirmed that it is committed to reaching a decision on its proposals as soon as possible.

6.3   I am meeting the NHS England Acting Director of Specialised Commissioning on 5th September to discuss the current position and will update the Board on the outcome on 7 September 2017.

7   Conclusion

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

John Adler
Chief Executive

31st August 2017

Quality & Performance

		YTD Plan	YTD Actual	Jul-17 Plan	Jul-17 Actual	Trend*	Compliant by?
Safe	**S1: Reduction for moderate harm and above (1 month in arrears)**	142	52	<12	18	🔴	Jul-17
	S2: Serious Incidents	<37	17	3	5	🔴	
	S10: Never events	0	3	0	0	🟢	
	S11: Clostridium Difficile	61	20	5	5	🟢	
	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	5.8	<5.6	5.8	🔴	
	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	17	<=7	4	🟢	
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%	95%	🟢	
Well Led	W13: % of Staff with Annual Appraisal	95%	91.7%	95%	91.7%	🔴	
	W14: Statutory and Mandatory Training	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%	9.0%	🔴	Oct-17
	E2: Mortality Published SHMI (Jan16-Dec 16)	99	101	99	101	🟢	
	E6: # Neck Femurs operated on 0-35hrs	72%	69.1%	72%	76.1%	🟢	
	E8: Stroke - 90% of Stay on a Stroke Unit (1 month in arrears)	80%	86.2%	80%	85.7%	🔴	
Responsive	R1: ED 4hr Waits UHL+UCC - Calendar Month	95%	78.6%	95%	79.8%	🔴	See Note 1
	R3: RTT waiting Times - Incompletes (UHL+Alliance)	92%	91.8%	92%	91.8%	🔴	
	R5: 6 week – Diagnostics Test Waiting Times (UHL+Alliance)	<1%	0.8%	<1%	0.8%	🟢	
	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%	1.6%	🟢	
	R14: % Ambulance Handover >60 Mins (CAD+)	TBC	4%	TBC	1%	🟢	TBC
	R15: % Ambulance handover >30mins & <60mins (CAD+)	TBC	10%	TBC	5%	🟢	TBC
	RC9: Cancer waiting 104+ days	0	12	0	12	🔴	

		YTD Plan	YTD Actual	Jun-17 Plan	Jun-17 Actual	Trend*	Compliant by?
Responsive Cancer	RC1: 2 week wait - All Suspected Cancer	93%	94.6%	93%	95.1%	🟢	
	RC3: 31 day target - All Cancers	96%	96.1%	96%	97.0%	🟢	See Note 1
	RC7: 62 day target - All Cancers	85%	79.0%	85%	77.4%	🔴	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	Jul-17 Plan	Jul-17 Actual	Trend*	
Finance	Surplus/(deficit) £m	(20.9)	(20.9)	(3.3)	(3.3)	🟢	
	Cashflow balance (as a measure of liquidity) £m	1.0	8.7	1.0	8.7	🔴	
	CIP £m	10.2	10.8	2.9	3.5	🟢	
	Capex £m	8.7	8.9	2.3	2.1	🔴	

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

* 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.

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	↔	2	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	3	↔	3	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	↔	3	EPB	IFPIC

UHL Risk Register Dashboard as at 31 July 17

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Impact	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	Georgina Kenney	↔	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	Kerry Johnston	↔	Harm	Workforce
3027	CHUGGS	If the UHL adult haemoglobinopathy service is not adequately resourced, then it will not function at its commissioned level	15	4	Ann Hunter	**NEW**	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	↔	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	Geraldine Ward	↔	Service disruption	Estates
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.	9 ↓	3	Anne Freestone	↓	Harm	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	↔	Service disruption	Workforce
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	Karen Jones	**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 resulting in potential financial penalties.	20	6	Susan Burton	↔	Harm	Workforce

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Impact	Thematic Analysis of Risk Causation
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
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	Gaby Harris	↔	Service disruption	Estates
2191	MSK	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
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
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	Procesesses 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	↔	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	Kerry Johnston	↔	Harm	Workforce
3044	ESM	If under achievement against key CQUIN Triggers, Then income will be affected.	16	1	Elaine Graves	↔	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
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
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

Risk ID	CMG	Risk Description	Current Risk Score	Target Risk Score	Risk Owner	Risk Movement	Thematic Analysis of Risk Impact	Thematic Analysis of Risk Causation
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	↔	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	↔	Harm	Workforce
3047	RRCV	If the service provisions for vascular access at GH is not adequately resourced to meet demands, then patients will experience significant delays for a PICC resulting in potential harm.	15	6	Sue Mason	**NEW**	Harm	Demand and Capacity
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 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	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 Impact	Thematic Analysis of Risk Causation
2466	ESM	Current lack of robust processes and systems in place for patients on Current lack of robust processes and systems in place for patients on DMARD and biologic therapies in Rheumatology resulting in a risk of patient harm due to delays in timely review of results and blood monitoring.	15 ↑	1	Alison Kinder	↑	Harm	Procesesses 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	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
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
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
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	↔	Harm	Workforce
2601	W&C	There is a risk of delay in gynaecology patient correspondence due to a backlog in typing	15	6	Donna Marshall	↔	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
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

NHS
Improvement

Sent via email
Karamjit Singh, Chair
John Adler, CEO

31st July 2017

Dear Karamjit and John,

Re: University Hospitals of Leicester NHS Trust ('the Trust') – Quarterly Review meeting on 12th July 2017

Thank you for your preparation and attendance at the quarterly review meeting on 12th July 2017.

You were required to attend because of NHS Improvement's concerns regarding your Trust's operational and financial performance. National NHSI colleagues and I are deeply concerned about your sustained poor A&E performance which has kept you consistently in the bottom 10 of all providers in the country. This cannot continue, the Trust has the estate and staff resource in place to support significantly improved A&E performance and to be one of the best performing teaching hospitals in the country. Given these factors I expect your Board to ensure underlying issues are rapidly resolved, and for improvement opportunities identified by Pauline Philips in her recent visit to be implemented at pace. I will meet with you both to discuss the next steps on this matter. I also continue to be concerned about plans in place to minimise your Trust's financial deficit and the impact this has on the Trusts ability to secure capital to support the longer term system plans.

Performance

The Trusts performance against operational targets remains challenged, however I note you are ahead of trajectory in terms of delivering the RTT Incomplete standard and have made progress to recovering your Cancer 62 day standard. You continue to deliver the diagnostics target on a consistent basis.

We discussed in detail the Trusts urgent care performance, you share my view that sustained poor performance is unacceptable to the population of Leicester, Leicestershire and Rutland and to the reputation of the Trust and its leadership team. The Trust outlined 4 areas that he and the team will focus on; these being data, demand and capacity, process and leadership. In terms of data the focus will be on identifying how clean it is, a move away from occupancy as the key metric replacing it with 20 measures of success from reception to seeing a clinician to enable a clear understanding of why the Trust "lose grip" going into the evening and overnight. I will require an update on each of these streams at our monthly A&E system escalation meeting; they will become a standard agenda item. With regard to demand and capacity the focus will be on right- sizing medical capacity 24/7. You currently appear to build up a strain in the system going into the evening when you have one fifth of the medical staffing capacity compared to during the day. You

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must ensure that you increase the volume of DCC's dedicated to delivering ED activity. At your A&E escalation meeting on 19th July I am expecting to see a clear plan at a granular level that will articulate what is changing in terms of medical staffing capacity. This includes the suggestion for the Trust to run a "perfect week/month" where you trial the right level of medical capacity 24/7.

In terms of process you have access to external support including ECIP to drive out inefficient ways of working which appear to show you are holding patients in the emergency department far longer than (clinically) they need to be. Finally, my team has put you in touch with the Leadership Centre to progress a piece of work to strengthen leadership across the urgent care pathway (ED and Acute Medicine). We have seen this work well at another large acute teaching Trust, I want you to progress this at pace.

Finance

As discussed at the meeting I am disappointed that the Trust did not sign up to its financial control total for 2017/18. Whilst I understand that your planned £27m deficit for 2017/18 is in line with your previously submitted LTFM, I am concerned about the Trust's overall plans to minimise its deficit position. NHSI colleagues will revisit the assumptions underlying the Trust's stated £20-25m structural deficit, including a review of the most recent work completed on this by EY.

The Trust outlined a key learning from the failure to deliver the 2016/17 financial plan was the need to identify additional financial headroom to offset the costs of unplanned winter pressures. You outlined action being taken to identify additional cost savings which will provide headroom as the Trust approaches winter, these include a review of the Trust's comprehensive CIP programme and a plan to reduce staff costs by £3.5m in-year (£7m full-year effect) through headcount reduction.

The Trust is also reviewing productivity savings opportunities identified through the model hospital. I expect the Trust to incorporate productivity savings which can reasonably be transacted in 2017/18 into its in-year review of CIP plans and ensure that there is a clear link between productivity opportunities and future CIP plans.

The Trust was subject to significant levels of commissioner income challenges in Q4 2016/17. Whilst the Trust was largely successful in defending commissioner challenges (£20m challenge, £1m financial impact), further improvements must be made to ensure that processes are improved to avoid and defend any future commissioner income challenges. In particular please ensure that any service or contract changes are formally documented in a contract variation agreement, and that planned improvements to flex and freeze processes are enacted.

The Trust confirmed the system readiness to consult on STP plans and that you are awaiting further confirmation of capital support for reconfiguration plans. NHSI will confirm next steps in the application process once these are known.

Finally, I am pleased the Trust is on track to deliver the agency control total based on current run-rate. I note that nursing agency spend has improved and that your key risk is medical locum spend where further scrutiny and challenge is required in relation to long standing locums. The Trust asked for advice on how to ensure that benefits of the new junior doctor contract are realised in relation to agency reduction plans. The 2016 TCS, Schedule 3, outlines contractual limits on working hours and rest periods. You should refer to the FAQ's (specifically Question 4) on the NHS Employers website using this link http://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff/doctors-and-dentists-in-training/terms-and-conditions-contracts/general-contract-faqs-updated-august for further advice and guidance.

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Quality

We discussed the Trusts readiness for its next CQC inspection and management of CCG concerns and general "noise" in the system. It was confirmed there is a meeting planned between the Trust and the CCG and this should be used to fully establish what the Commissioners quality concerns are and how the required assurance can be provided by the Trust

Areas of particular concern are the Trusts learning from never events and Sis, with the Trust having a spike in never events in May 2017.In addition there is particular focus regarding issues highlighted in relation to Oral and Maxillo-Facial Surgery (OMFS) and Cardio Respiratory services and the need for assurance the Board are sighted on any similar issues that may be occurring more widely within the Trust

The Trust discussed briefly the arrangements it has in place to oversee the action plan developed following the outcome of the last CQC inspection. The Trust will need to ensure there is sufficient focus on quality improvement, as well as compliance, through its established processes.

Next steps:

1. Trust to update on data, demand and capacity (including an increase in ED DCC's), process and leadership by 19th July 2017
2. Trust to confirm dates to undertake a perfect week/month in urgent care services
3. Trust to complete review of CIP plans by September 2017 and confirm revised CIP target which delivers headroom to offset unplanned winter pressures
4. NHSI to undertake a detailed review of the Trust's 'structural deficit' to be completed by the NHSI finance team by 29th September 2017.
5. Trust to scrutinise long standing locums with a plan to transfer to Trust payroll by the next PRM scheduled for 24th August 2017
6. NHSI to schedule a meeting between me, John Adler and Karamjit Singh asap.

If you have any queries in relation to this letter, please contact Jeffrey Worrall in the first instance via email at Jeff.Worrall@nhs.net.

Yours sincerely

P.P

Dale Bywater
Executive Regional Managing Director, Midlands and East

Cc: Jeff Worrall, Delivery and Improvement Director, M&E - Central and South Region

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