Report by Chief Executive – Monthly Update: November 2019

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

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)	N/A	
Executive Board	N/A	
Trust Board Committee	N/A	
Trust Board	N/A	

Executive Summary

Context

The Chief Executive's monthly update report to the Trust Board for November 2019 is attached. It includes:-

(a) the Quality and Performance Dashboard for September 2019 attached at appendix 1 (the full month 6 quality and performance report is available on the Trust's public website and is hyperlinked within this report);

(b) key issues relating to the Trust Priorities.

Questions

Does the Trust Board have any questions or comments about our performance and plans on the matters set out in the report?

Conclusion

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 the content of this month's report to the Board.

For Reference** (edit as appropriate)**:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Safely and timely discharge	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Estate investment and reconfiguration	[Yes]
e-Hospital	[Yes]
More embedded research	[Yes]
Better corporate services	[Yes]
Quality strategy development	[Yes]

3. Equality Impact Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A
- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required – None Required.
- How did the outcome of the EIA influence your Patient and Public Involvement ? N/A
- If an EIA was not carried out, what was the rationale for this decision? On the basis that this is a monthly update report.

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	ALL
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register	**X**	N/A
New Risk identified in paper: What ***type*** and ***description***?	N/A	N/A
None		

5. Scheduled date for the **next paper** on this topic: December 2019 Trust Board

6. Executive Summaries should not exceed **5 sides** [My paper does comply]

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th NOVEMBER 2019**

REPORT BY: **CHIEF EXECUTIVE**

SUBJECT: **MONTHLY UPDATE REPORT – NOVEMBER 2019**

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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) and Organisational Risk Register;

(c) key issues relating to our Trust Priorities, and

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

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

2 Quality and Performance Dashboard – September 2019

2.1 The Quality and Performance Dashboard for September 2019 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 People, Process and Performance Committee and Quality and Outcomes Committee. The quality and performance report month 6 is published on the Trust's website.

2.4 ***Good News:***

- **Mortality** – the latest published SHMI (period May 2018 to April 2019) has decreased to 99, and remains within the expected range.
- **Diagnostic 6 week wait –** standard achieved for 13 consecutive months.
- **52+ weeks wait –** has been compliant for 15 consecutive months.
- **Delayed transfers of care** - remain within the tolerance.
- **12 hour trolley wait -** 0 breaches reported.

- **CAS alerts** - compliant.
- **MRSA** – 0 cases reported.
- **Single Sex Accommodation Breaches** – 0 reported in September.
- **Pressure Ulcers** - 0 **Grade 4,** 1 **Grade 3** and 5 **Grade 2** reported during September.
- **Inpatient and Day Case Patient Satisfaction (FFT)** achieved 97% which is above the national average.
- **90% of Stay on a Stroke Unit** – threshold achieved with 89.5% reported in August.
- **TIA (high risk patients) –** threshold achieved with 57.1% reported in September.
- **2 Week Wait Cancer Symptomatic Breast** was 97.4% in August.
- **Annual Appraisal** is at 92.8%.
- **Statutory and Mandatory Training** compliance is currently at 95% and has therefore achieved the Trust target.

2.5 ***Bad News***

- **UHL ED 4 hour performance** – 71.1% for September, system performance (including LLR UCCs) was 80.5%.
- **Ambulance Handover 60+ minutes (CAD)** – performance at 8.1%.
- **Referral to treatment** – the number on the waiting list (now the primary performance measure) was above the NHSE/I trajectory, and 18 week performance was below the NHS Constitution standard at 82.0%.
- **Cancer Two Week Wait** was 91.4% in August against a target of 93%.
- **Cancer 31 day treatment** was 88.5% in August against a target of 96%.
- **Cancer 62 day treatment** was 72.4% in August against a target of 85%.
- **C DIFF** – 14 cases reported this month.
- **Fractured NOF** was 69.2% in September, YTD is below target which is 72%.
- **Cancelled operations OTD** - 1.2% reported in September.
- **Patients not rebooked within 28 days following late cancellation of surgery -** 26.

3. <u>Quality Strategy: Becoming the Best – Update</u>

3.1 The Design phase of the work on culture and leadership continues with inputs from our Improvement Agents and those who attended the recent Leadership and Consultant conferences in late September.

3.2 I summarise below the key themes – *positive* and *negative* – arising from our recent engagement with Managers and their teams on the launch of Becoming the Best:

<u>Positive Themes</u>

3.3 *This is* a *positive step, and an opportunity to reflect on what we can do differently*

3.4 The majority of the audience are positive, but as yet not transitioning from positive, to understanding where they fit into bringing it together, and we need to help join the

dots between what we are saying, where we are going and what that means to our people.

3.5 *I understand my place and ways I can get involved*

3.6 The feeling is that on top of understanding the direction of travel there are clear ways to get involved that people can and are acting upon.

3.7 *The direction that we are taking is simpler*, *clearer and more realistic than in the past but builds on what we do every day - care*

3.8 The sentiment is that we should be putting best care first every day, and rather than ripping up and starting again, this is us building on what has come before. There is a feeling that the plan is simpler and clearer than in the past, without lacking ambition.

3.9 *We need to tackle our culture and share* a *goal as one team - this is an opportunity*

3.10 Hangers on, decision pathways, ultimate responsibility, not sharing priorities, leadership not being visible and accountable – these are all things we have to tackle and this is an opportunity to help us succeed. We need a universal language across CMGs and directorates that pulls us in the same direction. We need to no longer be ok with average.

Negative Themes

3.11 *Current operational challenges - Time*, *People*, *Infrastructure*, *Priorities and Basics*

3.12 We can't get the basics right, but now we are talking about doing more. How can we given that we don't have the time to make available for engagement, the people to make it happen, or the infrastructure – digitally and physically to do the things we are supposed to be doing? There are too many priorities and a host of systemic issues, demands and pressures that make taking the step forward to better care seem impossible, even though the sentiment is good.

3.13 *We've seen all this before*

3.14 This is just another strategy. What did we learn from previous strategies that makes this one any different? This is a corporate initiative that needs front line feedback.

3.15 *Undervalued and Under-considered People and Areas*

3.16 The strategy is clinically focused so administration roles, partnerships and arms length services are not taken into account and as a result feel undervalued and not a part of the strategic vision, despite the crucial part that they play in the everyday of care. How can we make this work when not every voice is being heard and asked for action?

3.17 *Fiscal – is this achievable and sustainable?*

3.18 There is considerable investment but we are constantly under financial pressure. Is this a sustainable programme, is it going to continue to be invested in? Does it make sense to support communications and a glossy strategy when our front line and fundamental services are under financial pressure?

3.19 We are now working on how to build on what staff like about Becoming the Best, and to address their concerns. More about the action we will be taking as a result in my report to the Board next month.

4. Reconfiguration Programme

4.1 Work has commenced to develop and finalise the governance and management arrangements to complete our investment and reconfiguration plans, following September's announcement of the £450m capital investment. A report on these matters will be submitted to the Trust Board in December 2019. An important ingredient of these plans will be ensuring synergy with our Quality Strategy; while also ensuring that we do not take our eye off the ball in terms of our delivery of care during the course of the works.

4.2 In the meantime, we are working to refresh the pre-consultation business case and Full Business Case, which will be considered at a meeting of the NHS I/E Delivery and Quality Performance Committee-in-Common during December 2019.

4.3 In parallel, we are liaising with the Clinical Commissioning Groups to prepare a report for submission to the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee on 16th December 2019. We will seek the Joint Committee's views on our plans for consultation, and on the draft consultation document itself.

4.4 Subject to national approval, and to the views of the Joint Committee, formal public consultation will commence on 6th January 2020.

4.5 As stated above, a further update on the Programme will be submitted to the Board next month.

5. Emergency Care

5.1 October was a very challenged month, manifesting itself in very poor 4 hour standard and ambulance handover performance. The root cause of these issues is a significant shortfall in medical bed capacity at the Royal Infirmary which emerged after Q1 and was apparent when we reforecast based on actual experience in Q1. Up to that point the capacity plan was broadly in balance.

5.2 In response to the above situation we opened an additional ward at the Royal Infirmary to 14 beds on Tuesday 22 October. This was the earliest possible date as the ward was being refurbished. We will expand the ward to 28 beds as soon as possible, rather than waiting until January as originally planned. In addition we will be opening a further respiratory ward at Glenfield Hospital to 14 beds on 4th November. Once again, this is the earliest possible date as the ward is currently being used as a decant for another ward which was recently flooded and requires

remedial works as a result. We are also considering bringing forward the date when the additional ward expands to 28 beds.

5.3 I should emphasise that the opening of this capacity earlier than planned is an extremely challenging task due to staffing and other practical constraints. I am grateful to the many CMG, Nursing and Operations colleagues who have worked very hard to enable this to happen safely.

5.4 In addition to the above, there are two major action plans being overseen by the A&E Delivery Board. One relates to Demand Management and the other to Length of Stay Reduction. These are both designed to further reduce the capacity gap by reducing the number of admissions and reducing how long patients stay, respectively.

5.5 There is a system level model which builds on the UHL model to include the impact of system-level actions on our bed requirement, so that we can see the complete picture.

6. Board Assurance Framework (BAF) and Organisational Risk Register

6.1 The Trust Board approved the 2019/20 BAF for quarter one at its meeting in August 2019. Since that meeting, in line with our BAF governance arrangements, all Executive Director leads have reviewed and updated their principal risks for the period ending 30th September 2019.

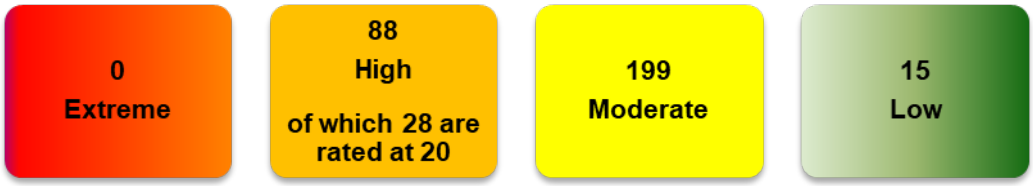
6.2 The highest rated principal risks on the BAF for the reporting period are:

PR No.	**Principal Risk Event** *If we don't put in place effective systems and processes to deal with the threats described in each principal risk… then it may result in…*	**Executive Lead Owner**	**Current Rating: July (L x I)**
1	Failure to deliver key performance standards for emergency, planned and cancer care	COO	5 x 4 = 20
5	Failure to recruit, develop and retain a workforce of sufficient quantity and skills	DPOD	5 x 4 = 20
6a	Serious disruption to the Trust's critical estates infrastructure	DEF	4 x 5 = 20
6b	Serious disruption to the Trust's critical IT infrastructure	CIO	4 x 5 = 20

6.3 Significant changes on the BAF during the reporting period include: for principal risk 4 (failure to deliver the Quality Strategy to plan) the current risk rating has increased to 12 (moderate) from 8, previously, while the Quality Strategy infrastructure is under development (including the QI team and Life QI tool). Principal risk 7 (concerning the reconfiguration programme) has had a full refresh following the Government's recent announcement to award UHL £450m. The new principal risk 7 title is: failure to deliver the Trust's site investment and reconfiguration programme within budget – with a current rating 9 (moderate). Principal risk 9 (failure to meet the financial control total including through improved productivity) current risk rating has reduced from 16 (high) to 12 (moderate) during September 2019.

Organisational Risk Register

6.4 The UHL risk register has been kept under review by the Executive Performance Board, the CMG Performance Review Meetings and across all CMGs via their monthly Board meetings during the reporting period and displays 302 organisational risk entries. A breakdown of the risk profile by current rating is shown in the graphic below:



6.5 Thematic analysis across the organisational risk register shows the most common risk causation theme across all CMGs is in relation to workforce capacity and capability. Thematic analysis shows the most common risk effect is potential for harm.

6.6 There have been six new risks rated high (i.e. scoring 15 and above) entered on the organisational risk register during the reporting period and, following discussion at the Audit Committee and Trust Board meetings in September and October, **appendix 2** to this paper has been included to provide further details about these risks for the information of the Board.

7. National Diabetes Awards

7.1 I am pleased to report on the success of two members of staff at the recent Quality in Care Diabetes awards, run by the PM Group.

7.2 Rachel Berrington, Senior Diabetes Nurse Specialist won Diabetes Healthcare Professional of the year in recognition of her raising the standards of care over and above her day to day role.

7.3 Rachel's achievements include the following:

- set up of protocols, guidelines and pathways to ensure Right person: Right time: Right care: Right place, always,
- instigated Root Cause Analysis to identify areas where improvements in provision could be made. Shared results and led actions at a LLR (Leicester, Leicestershire and Rutland) level,
- led NICE guidance Diabetic foot prevention and management,
- editorial Board journal Diabetic Foot,
- development, implementation and dissemination of training for casting with the diabetic foot nationwide,
- DAFNE educator,
- commissioned to develop and deliver face to face and digital education for HCPs and patients/carers though STP monies – incorporating roadshows, short programmes, toolkits for staff, including harder to reach groups, eg district nurses, care homes, community hospitals,

- key part in setting up the VALS (Vascular Limb Salvage Service) in the region,
- led work on urgo-start pathway LLR wide and helped steer it to a position on the formulary.

7.4 Sarah Lockwood-Lee, Children's Diabetes Support Worker won Outstanding Educator in Diabetes, in recognition of her work in leading the Deapp Diabetes Education Application which was started by the Children and Young People's East Midlands Diabetes Network (CYPEMDN).

7.5 Children and young people newly diagnosed with T1D are given Deapp to watch by a healthcare professional who will then play with the child using physical resources to check their knowledge. Sarah works in partnership with units across CYPEMDN to bring the scripts to life, and helped to design the resources and games; and with De Montfort University who turned the ideas into animations and physical resources. Sarah is instrumental in setting up and delivering the healthcare professional education programme, which teaches flipped learning to provide the same education in a very different mode of delivery.

8. Potential No Deal EU Exit Preparations

8.1 At the end of October 2019, the United Kingdom Government and the European Council agreed to extend Article 50 and thus the UK's membership of the EU until 31st January 2020. As a result, the NHS has paused its no deal plans which were due to come into force on 31st October 2019.

8.2 The nature of the extension is that if the Withdrawal Agreement is ratified by both the UK and European Parliaments, the UK will leave with a deal. If ratification has not happened by 31st January 2020, the legal default is that the UK will leave the EU without a deal.

8.3 Nationally, the NHS will use the period of the extension to renew its plans for all scenarios, including a deal or no deal.

8.4 Locally, we will continue to work within the national framework to ensure we are as ready as we can be when the UK leaves the EU.

8.5 As Senior Responsible Officer, the Director of Corporate and Legal Affairs will continue to lead this work and report further to the Trust Board in due course on our EU exit preparations, in the light of further guidance from the Department of Health and Social Care, once received.

9. Conclusion

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

John Adler
Chief Executive

31st October 2019

Quality and Performance Report Board Summary September 2019

This dashboard uses icons to indicate if a process is showing special cause or common cause variation. It also indicates whether the process is able to meet any stated target. Here is a key to the icons

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)
	Special cause variation - improvement (indicator where low is good)

These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of the rules are present then the metric is showing common cause variation.

- An upwards or downwards trend in performance for seven or more consecutive months.
- Seven or more months above or below the average.
- One month or more outside the control limits .

Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

Green indicates that the metric has passed the monthly or YTD target while **Red** indicates a failure to do so.

The trend shows performance for the most recent 13 months.

Data Quality Assessment - The Data Quality Forum panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance by best endeavours that it is of suitably high quality. The forum provides scrutiny and challenge on the quality of data presented against the dimensions of accuracy, validity, reliability, timeliness, relevance and completeness.

Quality and Performance Report Board Summary September 2019

Domain	KPI	Target	Jul-19	Aug-19	Sep-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Safe	Never events	0	0	0	1	2	?			May-17
	Overdue CAS alerts	0	0	0	0	1	?			Nov-16
	% of all adults VTE Risk Assessment on Admission	95.0%	98.2%	97.8%	98.2%	98.1%	?	H		Nov-16
	Emergency C-section rate	TBC	20.2%	17.8%	21.8%	19.4%				TBC
	Clostridium Difficile	108	14	6	14	54	?			Nov-17
	Clostridium Difficile Rate	TBC	32.1	13.7	33.1	20.9				TBC
	MRSA Total	0	0	1	0	1	?			Nov-17
	E. Coli Bacteraemias Acute	TBC	10	11	6	53				Jun-18
	MSSA Acute	TBC	4	2	4	18				Nov-17
	All falls reported per 1000 bed stays	6.02	5.2	4.5		4.9	?			Jun-18
	Avoidable pressure ulcers G4	0	0	0	0	0	?	L		Aug-17
	Avoidable pressure ulcers G3	3	0	0	1	1	P			Aug-17
	Avoidable pressure ulcers G2	7	5	2	5	29	?			Aug-17
	Dementia assessment and referral - Percentage to whom case finding is applied	TBC	89.3%	88.4%		87.8%		L		TBC
	Dementia assessment and referral - Percentage with a diagnostic assessment	TBC	70.8%	54.7%		56.3%		L		TBC
	Dementia assessment and referral - Percentage of cases referred to specialist	TBC	100%	100%		100%				TBC

Domain	KPI	Target	Jul-19	Aug-19	Sep-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Caring	Staff Survey Recommend for treatment	TBC	78%	78%	78%	76%				Aug-17
	Single Sex Breaches	0	7	0	0	7	?			Dec-16
	Inpatient and Daycase F&F Test % Positive	96%	97%	97%	97%	97%	P			Jun-17
	A&E F&F Test % Positive	94%	94%	94%	93%	94%	?			Jun-17
	Maternity F&F Test % Positive	96%	95%	96%	94%	93%	?			Jun-17
	Outpatient F&F Test % Positive	94%	95%	95%	95%	95%	?			Jun-17
	Written complaints	TBC	228	223	212	1283		H		TBC

Domain	KPI	Target	Jul-19	Aug-19	Sep-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Well Led	Staff Survey % Recommend as Place to Work	TBC	61.0%	61.0%	61.0%	60.0%				Sep-17
	Turnover Rate	10%	8.9%	9.1%	8.9%	8.9%	P			Nov-17
	Sickness Absense	3%	3.9%	3.9%		3.8%	F			Oct-16
	% of Staff with Annual Appraisal	95%	91.8%	91.9%	92.8%	92.8%	F	H		Dec-16
	Statutory and Mandatory Training	95%	93.0%	93.0%	95.0%	95.0%	F	H		Dec-16
	Nursing Vacancies	TBC	13.6%	12.2%		12.2%				Dec-17

Quality and Performance Report Board Summary September 2019

Domain	KPI	Target	Jul-19	Aug-19	Sep-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Effective	Mortality Published SHMI	99	99	100	99	99 (May 18 Apr 19)				Sep-16
	Mortality 12 months HSMR	99	95	93	92	92 (Jun 18 to May 19)				Sep-16
	Crude Mortality Rate	TBC	1.0%	0.9%	1.1%	1.0%		L		Sep-16
	Emergency Readmissions within 30 Days	8.5%	8.9%	9.1%		9.0%	?			Jun-17
	Emergency Readmissions within 48 hours	TBC	1.0%	1.1%		1.1%				TBC
	No of #neck of femurs operated on 0-35hrs	72%	58.3%	47.4%	69.2%	68.1%	?			Sep-16
	Stroke - 90% Stay on a Stroke Unit	80%	88.0%	89.5%		87.8%	?			Apr-18
	Stroke TIA Clinic Within 24hrs	60%	78.9%	72.4%	57.1%	68.1%	?			Apr-18

Domain	KPI	Target	Jul-19	Aug-19	Sep-19	YTD	Assurance	Variation	Trend variation	Data Quality Assessment
Responsive	ED 4 hour waits UHL	95%	72.0%	69.7%	71.4%	72.8%	F	L		Aug-17
	ED 4 hour waits Acute Footprint	95%	80.6%	79.4%	80.1%	80.9%	F			Aug-17
	12 hour trolley waits in A&E	0	0	0	0	0	P	L		Mar-19
	Ambulance handover >60mins	0.0%	10.2%	10.1%	8.1%	7.0%	?			TBC
	RTT Incompletes	92%	83.3%	81.6%	82.0%	82.0%	F	L		Nov-16
	RTT Wating 52+ Weeks	0	0	0	0	0	?	L		Nov-16
	Total Number of Incompletes	64,404	65,600	65,903	66629	66,629	?			TBC
	6 Week Diagnostic Test Waiting Times	1.0%	0.9%	1.0%	0.8%	0.8%	?	L		Mar-19
	Cancelled Patients not offered <28 Days	0	17	26	26	122	F			Jul-18
	% Operations Cancelled OTD	1.0%	1.3%	1.3%	1.2%	1.2%	?			Jul-18
	Delayed Transfers of Care	3.5%	1.8%	1.6%	1.7%	1.6%	P			Oct-17
	Super Stranded Patients	135	160	169	186	186	F			TBC
	Inpatient Average LOS	TBC	3.6	3.6	3.5	3.5				TBC
	Emergency Average LOS	TBC	4.6	4.4	4.4	4.5				TBC

Domain	KPI	Target	Jun-19	Jul-19	Aug-19	YTD	Assurance	Variation	Trend	Data Quality Assessment
Responsive - Cancer	2WW	93%	91.0%	91.8%	91.4%	92.7%	?			Jun-16
	2WW Breast	93%	94.5%	91.9%	97.4%	93.6%	?	H		Jun-16
	31 Day	96%	93.9%	92.9%	88.5%	92.8%	?	L		Jun-16
	31 Day Drugs	98%	99.2%	100%	100%	99.6%	?			Jun-16
	31 Day Sub Surgery	94%	78.1%	86.7%	91.6%	85.9%	?			Jun-16
	31 Day Radiotherapy	94%	96.8%	97.0%	95.0%	97.2%	?			Jun-16
	Cancer 62 Day	85%	74.4%	76.3%	72.4%	74.8%	F			Jun-16
	Cancer 62 Day Consultant Screening	90%	78.9%	85.3%	82.1%	83.2%	?			Jun-16

Risk ID	CMG	Specialty	Opened Date	Review Date	Risk Description	Risk Causation & Impact	Controls in place	Impact	Likelihood	Current risk Score	Action summary	Target risk Score	Risk Owner	Risk Type	Compliance
3519	CMG 1- CH&GCS	Urology	06/Sep/19	31/12/2019	If availability of essential replacement uroscopes in Urology is not adequaltely resourced, then it may result in delays with patient treatment due to insufficient effective/working scopes available to undertake booked lists, leading to potential for harm (increased patient waits both cancer and RTT), disruption to the service and adverse effect on reputation.	This may lead to a risk of disruption to the service, increased patient waits both cancer and RTT, potential for patients harm due to delays and adverse effect on Trust ans service reputation. Patients may be cancelled due to insufficient effective/working scopes available to undertake booked lists. There is also a risk of incomplete and/or repeat procedures if the scopes are poor quality or fail during a procedure. Cause: a lack of investment in medical equipment replacement programme - insufficient investment to procure replacement uroscopes - leading to scopes being beyond their recommended life span due to wear and tear, old technology and in some cases obsolete technology. HARM: *Failure to meet RTT and cancer targets *Repeat procedures *Missed pathology/equipment (ref: incident W289937) REPUTATION: *UHL using out of date technology *Technology slippage *Unattractive workplace/unable to attract or retain staff *Potential CQC non-compliance. SERVICE DISRUPTION: *Failure to treat/diagnose patients *Cancellations of patients (diagnostic and therapeutic) *Increased waiting lists. FINANCIAL LOSS: *Unplanned financial replacement of equipment *Loss of new/additional income *Fines related to target failures *Failure to attract new contracts.	Preventive: Maintain contracts (external/in-house) in place where possible to support existing equipment. Inspection of scopes prior to use (removal form service if not working) Detective: Datix incident reports Manufacturers reports Performance data Corrective: Exploring alternative funding streams; e.g. charity/leasing ect. Emergency capital bid in case of failure.	Major	Likely	16	Scopes to be managed by REDS - including replacement /loan equipment. Review 31 12-19 Explore alternative funding streams for additional scopes - Review 31/12/19 Develop equipment replacement programme - Review 31/12/19	8	Jaqui Gilmore	CMG Risk	
3534	CMG 2 - RRCV		23/08/2019	31/10/2019	If RRCV CMG are unable to recruit and retain to Trust Grade level medical staff, then it may result in widespread delays with patient diagnosis or treatment, leading to potential harm and disruption to the base wards and critical areas (CDU & CCU)	Cause: Difficulties to recruit and retain to Trust Grade level medical staffing The team and the RRCV CMG senior team, continually review possible options and solutions to cover the clinical gaps on base wards and Clinical Decision Unit (CDU) however it is acknowledged this is becoming more difficult to achieve, with changes in medical funding and reduced number of available trained/experienced medical staff. Exacerbating factor: Unable to recruit agency locums to fill gaps, particularly at SpR level. Harm (Patient/Non Patients): If unable to staff the rota with safe numbers of medical staff at all levels for the base wards and critical areas (CDU & CCU) this will present a patient safety risk, by increased waiting times, delays to senior review and less effective bed flow . In turn this will impact on the flow and capacity for UHL Trust Potential increase in number of patient complaints and Datix incidents Service Disruption: If unable to staff the Cardiology rotas, to maintain a safe number of medical staffing, there is a potential risk to the CDU work stream and standard operating procedure, which will also impact the take of patients from LRI and other admissions. Risk of losing junior staffing via Deanery and training needs being jeopardised Impact on CDU metrics and performance Impact on nursing staff pressures Impact on RRCV resources to manage the medical gaps and provide assurances and solutions to ensure safe cover the base wards and CDU Impact on RRCV to plan and to support 201 winter pressures. Removal of SpR's within Cardiology Financial Loss: The impact of financial loss is directly from patient income if patients are unable to be treated and/or seen in CDU. Increase in financial costs for locum/Agency spend Impact on the RRCV financial position and ability to support operational plan Reputation: HEE-EM /Deanery –External inspection planned for July 2017 for Cardiology and Respiratory services Drs in training – potentially impacts on Drs wanting to work at Leicester	Preventive: Medical workforce Manager and JDA team monitor the current rotas to identify significant gaps and complete the necessary actions and planning to ensure cover or reduce the number of medical gaps. Planning of rotations during the 2019/20 with the support of Medical HR to identify gaps and complete the necessary actions to ensure cover or reduce the number of medical gaps. Efficient recruitment processes and rolling adverts. Maximising current resources to cover the gaps where possible Effective communication with medical group and escalation procedures Increased educational sessions in Trust Grade job plan to develop skills and career progression with exposure in other areas within Cardiology. Provide a more supportive network to Trust Grades within cardiology Detective: RRCV CMG performance meetings where medical cover is discussed. Respiratory and Cardiology Board meetings with attendance from Education representatives to escalate concerns. Junior Dr and other Dr forums and 'gripe' system to identify themes of issues. Review of different working models and RRCV investment to explore alternative options including the use of Advanced Care Practitioners (ACPs) and Physician Associate (PA). Benchmarking from other Trusts and Organisations for different ways of working Corrective: Recruitment to gaps Action plan for HEE-EM Scheduling of RRCV meetings with relevant personnel to review gaps and solutions - e.g. time out Cross site / CMG working	Major	Likely	16	Service Manager and JDA team to continue to monitor rotation gaps and take the necessary steps to make base wards and CDU safe ensuring escalation is completed when required - 31.12.19 Effective and timely recruitment completed with the support of the medical HR team to fill medical staffing gaps and reduce risk as much as possible - 31.12.19 Frequent scheduled meetings to ensure the monitoring of the HEE-EM action plan and reassurance of actions being completed. - 31.12.19 RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 30/10/2019 Recruitment to 5wte Consultant Cardiologist to strengthen senior supervision on wards - 31/12/2019 Implement twilight cardiology shift on CDU to help manage evening workload - 31.10.19	12	Sarah Taylor	CMG Risk	
3533	CMG 2 - RRCV	Cardiology	23/08/2019	31/12/2019	If there is insufficient Medical staff at consultant and registrar level within cardiology services to meet inpatient and outpatient demand, then it may result in widespread delays with patient diagnosis, prognosis and treatment, leading to potential patient harm.	Cause: If we do not effectively recruit to current Medical staffing vacancies at consultant level and registrar gaps within cardiology Services, Then (event): It may result in widespread delays with patient diagnosis, prognosis and treatment, leading to potential patient harm. Harm (Patient/Non Patients): Increase in waiting times for treatment and review in outpatients with a numbers of patients breaching on RTT pathway. If unable to staff the rota with safe numbers of Consultants and registrars, on base wards and critical areas (CDU & CCU) this will present a risk to patient care/experience,by increased waiting times, delays to senior review and less effective bed flow. Poor prognosis/outcome for patients Delay in diagnosis and subsequent treatment plan Increase in complaints Reduced supervision and teaching of trainees. Sustained stress / anxiety for patients and staff (Increased sickness absence due to excessive workload). Reputation: Widespread reduction in public, commissioner and regulator confidence. Drs in training - potentially impacts on Drs wanting to work at Leicester. Not recognised as a centre for all type of research. Service Disruption: Gaps in ward cover provision and reduced senior reviews for inpatients. Risk of losing junior staffing via Deanery and training needs being jeopardised. Impact on nursing base ward and CDU Financial Loss: Potentially litigation claim Increase in penalty fines Delay income Increase in waiting list payments Pay cost increase due to locum agency spend Impact on the RRCV financial position and ability to support operational plan	Preventive: Cardiology Service Manager allocated to lead on recruitment Plan to undertake additional clinics (Super Saturday)x3 Service Manager and JDA team monitor the current rotas to identify significant gaps and complete the necessary actions and planning to ensure cover or reduce the number of medical gaps Maximising current resources to cover the gaps where possible Effective communication with medical group and escalation procedures Locum/Agency support being sourced Detective: Marked Increase in complaints Increase in enquires from patients /GP's Monitoring of complaints and staff concerns at RRCV CMG Board meetings Cardiology Board meetings with attendance from Education representatives to escalate concerns Junior Dr and other Dr forums and monitoring of concerns expressed through the 'gripe' system to identify themes of issues Corrective: Appointment of locums to bridge the gap Recruitment to gaps in a timely manner Implement improved allocation of leave throughout the year Implementation of the COW model once all vacancies are appointed to.	Major	Likely	16	Effective and timely recruitment supported by Service Manager and medical HR team to fill medical staffing gaps and reduce risk. - 31.12.19 Service Manager and JDA team to continue to monitor rotation gaps and take the necessary steps to make base wards and CDU safe ensuring escalation is completed when required - 31.12.19 RRCV CMG winter and operational plans and escalation of issues to appropriate Executive Trust Board(s) - 31/10/2019 Frequent monitoring of the HEE-EM action plan and reassurance of actions being completed - 31.12.19 Frequent monitoring of the HEE-EM action plan and reassurance of actions being completed - 31.12.19	8	Sarah Taylor	CMG Risk	
3514	CMG 6 - CSI	Pathology- Cellular Pathology	04/Sep/19	15/12/2019	If there are insufficient staffing resources in the Cellular Pathology Service to meet diagnostic TRT targets, then it may result in widespread delays to patient receiving results and treatment, leading to potential patient harm and affecting the reputation of the service.	The UHL Cellular Pathology Service has failed to meet the required TATs for diagnostic specimens since 2012. The causes of this are multifactorial but include increased workload complexity, difficulty recruiting Consultant Histologists, high turnover of laboratory staff and limited investment in service improvement. The backlog of work has reached a level where a recent UKAS inspection resulted in the suspension of the service's UKAS accreditation due to concerns about the department's ability to rectify the issues. Resulting in - Patient harm and delays to patient pathways Harm (Patient): Failure to meet the turnaround time will lead to delays to patients receiving results and subsequently possible delays in treatment. If delays are significant a new cancer may not be identified within the optimal time for treatment resulting in significant patient harm. Harm (Non Patients): Increased levels of employee stress and sicknesses as staff are under extreme pressure because of the large backlog of samples, blocks, reporting and typing. Reputation: A core pathology service being unable to meet the national TATs for diagnostic samples will adversely affect the reputation of the Trust. If patient harm results from delayed treatment the Trust may be criticised in the National/Local press. Loss of UKAS accreditation Service Disruption: High staff workloads and lack of time for training impact on the department's ability to recruit Consultant Histopathologist and qualified laboratory staff. These staff are in limited supply and may choose to work elsewhere. Financial Loss: Compliance with national targets is a desirable element of most tenders for Pathology Services. The Cellular Pathology Service will be at a significant disadvantage when bidding for external work until TATs can be improved. The Trust may incur financial penalties if TATs for patient diagnosis and treatment are missed.	Preventive: The Cellular Pathology Service's TATs are closely monitored and known 2WW samples are prioritised to reduce delays to patient pathways. Bank and agency staff are used when possible to support service provision and overtime is offered to all laboratory staff and office. However this is not a sustainable solution, experienced agency staff are in short supply and staff are exhausted doing continual overtime. Annual leave Is being actively managed. A robust training plan is in place to bring new staff up to competence as quickly as possible. Voice recognition software is used by medical staff for reporting. Detective: Monitoring of key performance indicators. Monitoring of staff sickness. Monitoring patient/clinician complaints. Corrective: Staff are mobilised into operational areas leading to a risk of failing to maintain the Quality Management System.	Major	Likely	16	Approve training plan for new staff - Dec 19 Complete audit of workload changes and TAT improvements - April 2020. Complete implementation of DXC LIMS - Nov 2019	4	Matthew Prattfield	CMG Risk	
3537	Corporate Nursing		26/09/2019	31/12/2019	If the Safeguarding Electronic Notes System ("SENS") were to develop a fault with no IT support services in place to rectify the issue, and it is not possible to keep the system updated (last updated January 2016 prior to Working Together 2016 and 2018), then it may result in information about vulnerable patients not being able to be retrieved by clinical staff, leading to potential harm, adverse reputation and financial penalty	If (cause)...The Safeguarding Electronic Notes system cannot be updated and has decreasing functionality due to the volume of essential data stored. Therefore the database is unable to be adapted to meet current CQC recommendations to store additional data and extend access to the system for wider access to clinical staff The system cannot be adapted to ensure new information fields are added to effectively monitor individual cases and look for service trends Then (event)...then it may result in information about vulnerable patients not being able to be retrieved by clinical staff Leading to Harm (Patient/Non Patients): Risk of repeated harm to vulnerable patients due to information not being able to be retrieved by clinical staff Delays in dealing with cases and therefore risk to patients Risk of not being able to pull accurate data for reporting/ review System unable to track user entry or prevent entries and full records being edited or deleted, non compliant with new information governance requirements Reputation: Risk to the reputation of the service and Trust as a result of significant adverse media attention if serious case reviews identified inadequate safeguarding services found to be performed inadequately. Also risk if negative results following external safeguarding reviews i.e. CCG quality review visits. Risk that the trust cannot achieve CQC recommendations for information / record keeping Unable to provide confirmation that the current system adheres to Information Governance legislation since March 2018. Service Disruption: All safeguarding data is recorded within SENS for adult , child and maternity safeguarding over 80,000 cases stores on the system, system is now unable to retrieve data through the search facility , meaning some data that is stored cannot be readily retrieved. Out of hours clinical staff are unable to access safeguarding records, which assist in decision making. Delay in forwarding information to external agencies (liaison to LPT, safeguarding to social care). If enforcement action was taken there is no identified solution to address the system faults. (IT have advised that a new database should be developed). Financial Loss: The risk of financial penalties for failing to meet our duties in particular around Data Protection.	Preventive: SENS data sits on data drives external to the front-facing SENS package and is currently secure and safe Detective: Monthly monitoring through review at the Trust Safeguarding Assurance Committee Corrective: There is a fall back paper record system in place should SENS become unavailable, but this has limited functionality.	Major	Likely	16	IT has recommended that a new database is developed as they are unable to put in system patches to the present system. Safeguarding to investigate new database and identify funding, following which there'll be a period to procure and implement the new system - review progress 31/10/19	12	Michael Clayton	Corporate Risk	

Risk ID	CMG	Specialty	Opened Date	Review Date	Risk Description	Risk Causation & Impact	Controls in place	Impact	Likelihood	Current risk Score	Action summary	Target risk Score	Risk Owner	Risk Type	Compliance
3938	Corporate Nursing		20/02/2019	31/12/2019	If there is continued under achievement against key safeguarding performance indicators and safeguarding standards, then it may result in failure to achieve compliance with regulations & standards and delays in safeguarding processes or care and treatment decisions, leading to potential for harm and adverse reputation	Cause: Lack of staff in Safeguarding team Resulting in (effect)… Harm (Patient/Non Patients): "Risk of repeated harm to vulnerable patients as team unable to respond to referrals within timeframe's. "Delays to care and treatment as team unable to facilitate MCA Best Interests Meetings, and also unable to provide timely written record of decision due to lack of admin support (this results in further delays). "Increased length of stay due to delays in dealing with safeguarding cases, which may result in delayed discharges. "Failure to uphold patients' human rights to liberty and freedom due to inadequate escalation process re unlawful DoLS (must do in current CQC action plan. "Patients' rights of appeal (against DoLS) not being upheld (as noted by CQC). "Patients may experience unnecessary restrictions / restraints due to lack of review and oversight by safeguarding nurses (MCA/DoLS). "Limited ability of safeguarding nurses to develop and deliver safeguarding training. "Limited ability of safeguarding nurses to see patients in clinical areas due to office pressures. "Reduced well-being of safeguarding nurses as they are completing essential admin tasks at home (in their own time) to ensure service provision in hours. "Limited opportunities for development and supervision for team members "Pressure on safeguarding clinical staff to complete essential admin tasks - leads to frustration as team cannot fulfil their nursing roles (wrong people wrong time). "Impact on staff morale as inequitable service across safeguarding team (Childrens team have significant admin support) Reputation: "Non-compliance with CQC KLOE - current must do action re DoLS. "Potential for critical reports from CCGs / CQC re failure to meet safeguarding standards. "Loss of reputation if failings identified following SARs and DHRs (these are reported in public domain). "Potential for negative Coroners rulings. "Failure to meet obligations under MCA, DOLS and MHA (e.g. team cannot review every patient detained under DOLS due to workload and demand). "Risk to the reputation of the service and Trust as a result of significant adverse media attention if safeguarding case reviews identify inadequate safeguarding service "Failure to meet statutory obligations / standards i.e. CQC / Quality Schedules / CCG Assurance Tool / SAAF. "Failure to complete timely CQC DoLS Notifications.	Preventive: Prioritisation of workload - using an established risk prioritisation tool Paperless service - reduces risks of information / paper loss Safeguarding team are completing essential work/reports at home, but this is not sustainable long term Child Safeguarding admin is completing some limited essential admin tasks but limited due to own workload Safeguarding nurses are completing all other essential admin tasks but this reduces ability to assess / review patients and achieve all other essential roe functions. Safeguarding nurses are not attending any multiagency meetings, but this reduces their opportunities for development and limits succession planning Team are not delivering widespread face to face training, although this reduces staff development and learning opportunities and has a knock on effect on organisational ability to manage safeguarding issues. Team are using local thresholds to ensure they respond to issues appropriately Detective: Slippage in responding to safeguarding referrals, particularly lower risk cases. Failure to complete essential admin tasks i.e. not meeting deadlines for SAR reports and S42 enquiry reports.	Major	Likely	16	Identify funding and recruit admin support for safeguarding team - 31/12/19	8	Michael Clayton	Corporate Risk	