

Board of Directors (Public)

Item 4.5

Board Report

Subject: CEO's Report
Date of meeting: Tuesday 31st March 2015
Prepared by: Executive Team
Presented by: Jane Tomkinson, Chief Executive

Data Quality Rating	BAF Ref	Impact on BAF Risk rating
n/a	1-9	None

1. Introduction

The purpose of the CEO's Report is to inform the Board of Directors of on-going strategic and operational issues, regulatory updates and formal notification of top risks as listed on the Trust's risk register.

2. Appointment of Medical Director

I am pleased to announce the appointment of Dr Raph Perry who will take up role of Medical Director in July 2015.

3. Clinical Divisional Structures and appointment of leadership teams

I am delighted to announce that the following have been appointed as Associate Medical Directors within the new Clinical Divisions:-

- Dr. John Morris – Medicine Division
- Mr. Aung Oo – Surgical Division
- Mr Nigel Scawn - Clinical Services Division

The new AMDs will take up their duties with effect from 1st April 2015.

Following a very successful recruitment campaign (42 applications) the selection process for the Divisional Head of Operations positions were held on Friday 20th March 2015. Appointments to the Divisional Head of Nursing posts will take place at the beginning of April 2015. It is anticipated that the full new senior leadership teams will be in place by July 2015.

4. Listening Into Action (LiA)

Following the feedback from the 2014 Staff Survey and the Mutuels Research Project, it has become apparent that employees are overwhelmingly in support of greater engagement and involvement in Trust decisions.

The Trust will be part of cohort 8 in joining 50 Trusts in adopting the LiA approach to building staff engagement and involvement. The Listening into Action programme is an intensive journey over an initial 12 month programme designed to lead a shift in culture built by involving staff to make improvements to their experience, operational services and patient experience.

Organisations who have already taken part in LiA have experienced significant positive shifts in their staff survey results and the HSJ award for staff engagement has been won by LiA trusts for the last 3 years.

The programme, which I will lead, commences on 24th March 2015 with the aim of involving as many staff, particularly clinicians in the process

5. Strategic Partnerships Update

Name of local Trust	Opportunity/Discussions	Progress
Wirral University Teaching Hospital	Joint posts to support Cardiology at Arrowe Park. Possible options around LHCH@ model and Cardiology GPSI posts in the future.	PCI Consultant post – Dr Ali started in November as a joint appointment. EP Consultant post agreed with WUTH, 60/40 split with the majority at WUTH. Job plan and advert currently being agreed. We are also delivering sessions for stress echo with one of our new imaging cardiologists.
Southport and Ormskirk Hospital NHS Trust	Opportunities to support the Southport Cardiology Service including discussions on rapid access chest pain and providing stress echo sessions.	We are currently supporting with some additional outpatient clinics to reduce a backlog of patients waiting appointments. We are also looking at options for two joint posts to support the inpatient Cardiology service at WUTH again on a 60/40 split post basis.
St Helens and Knowsley Teaching Hospital NHS Trust	Joint posts	We are currently out to advert for a joint PCI post with interviews later this month. There are further discussions to be held regarding further development opportunities.
Warrington and Halton Hospitals NHSFT	Discussions regarding Warrington setting up a local PCI service are on hold in anticipation of the specialist commissioner review of cardiac services in the North West.	We are currently awaiting the review report which was due to be published in January 2015 but is still awaited. There is a proposed date for a “workshop” in April 2015
Aintree University Hospital NHSFT	Joint posts, new models of care.	Initial meeting held with Aintree and a further meeting is planned. This also links into the on-going work as part of the Healthy Liverpool Cardiology group. We currently provide an EPS clinic at Aintree.
Alder Hey Children's Hospital	Partnership opportunity with Alder Hey to provide a “Liverpool” model of care for ACHD patients. This partnership would also include	The service model is currently being developed and we have a project board and working group structure in place. We have attended all the NHS

	the Liverpool Women's Hospital and RLBUTH.	England meetings and await a letter to be sent all Trust asking if they are prepared to collaborate on delivering the standards ahead of a competitive process. We have held an external "peer" review of our proposals with the ACHD Cardiologist from Birmingham and this has proven very beneficial in helping shape our response to the standards.
Royal Liverpool and Broadgreen University Hospital NHS Trust – Upper GI Service Transfer	To transfer Upper GI cancer services to the Royal site.	We have been given specialist commissioner approval to proceed however this requires further discussion on the model required to deliver the service.

6. Healthy Liverpool Programme (HLP)

The leadership team is to further refine the vision and ensure that the 3 key tenets of service, education and research are articulated and developed into a compelling story that will resonate with the public.

A listening event will be held on 27th March 2015 to engage further with the community and explore how the public feel about healthcare services in Liverpool.

CEOs are to consider sharing key risks and working together to avoid any individual organisation moving into the failure regime which will distract from delivery of HLP goals.

Feedback from the clinical summit held on 27th February 2015 (RLBUHT and Aintree) is to be shared and further consultation is to take place with specialist providers, including LHCH for cardiology.

There is recognition of the need to continue further engagement with Chairs, NEDs and Medical Directors to ensure alignment of the vision and secure the involvement of Liverpool Health Partners to reach a collective vision for Liverpool hospitals.

Consideration will be given to the impact of devolution in Manchester and the areas in which Liverpool and Manchester will need to collaborate for specialist service provision in the Northwest.

7. Regulatory Updates

CQC –The CQC has published guidance for providers on meeting two groups of regulations:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Care Quality Commission (Registration) Regulations 2009 (Part 4)

The guidance was circulated to all Directors in the February 2015 e pack, along with the CQC's revised Enforcement Policy.

The guidance applies from 1 April 2015, and will replace in its entirety CQC's *Guidance about Compliance: Essential standards of quality and safety* and its 28 outcomes.

Monitor – The 2015/16 planning timetable has been revised. The draft annual plan will now be submitted mid-day 7th April with the final plan submission scheduled for mid- day14th May 2015. The Trust has responded to Monitor's/NHS England's tariff options choice letter (dated 18th February) and confirmed its choice of the tariff default rollover (DTR) option. This was in light as discussed at Board strategic session risk on loss of CQUIN mitigated by tariff remaining at

2014/15 prices and no marginal tariff for high cost drugs and devices. Feedback from Monitor on annual plan submissions is expected by July 2015.

8. Top Operational Risks

Risk	Current Risk Score	Mitigation
There is a risk to the delivery of the 18 week waiting time standard caused by inadequate capacity leading to delayed patient treatment, reduced patient satisfaction and regulatory breach	9	Provision of additional external capacity 18 weeks training Patient by patient management & data validation
If the shortfall in junior doctor staffing is not mitigated with an alternative, then patient care will be suboptimal and patient harm may occur	9	Steering Group plan to provide alternative safe cover.
If the systems used to manage referrals, both in technical terms OnBase – and administration systems continue to be poor there is the potential for referrals to be missed	9	New quality assurance process implemented for admin function. Weekly validation and referrals.
Failure to deliver cost improvement plan	6	Enhanced monitoring and revised plans; In year slippage mitigated by high activity related income.
If we fail to recruit to the required numbers of staff due to staff turnover within Cedar ward then services and RTT may be affected	6	Active recruitment campaign: • Reassignment of staff • Bank and agency
If there is no agreed standard for the review of diagnostics before patients being listed for surgery then there is the potential for never events to occur and patient harm to happen	6	Best practice reconfirmed by Deputy MD monitoring of alerts.
If industrial action takes place then service continuity will be disrupted	4	Threat management by working group
If the process for clerking of medication history (OMR) and subsequent conversion to an in-patient prescription (ORM) is not utilised consistently then medication errors may occur	4	Training & pharmacist verification
If the Trust fails to recognise changes in the safety culture in the workforce then there is the potential for patient harm	4	Speak out safely campaign Sign up to safety campaign
If radiology alerts are not actioned then there is the potential that a radiologist instruction will be missed	4	Manual follow up of all alerts Secure health messaging (pending)
If there is no agreed standard for the electronic transfer of diagnostic information from referral hospitals then delay to treat will occur	4	Direct request for information from referring Trust
If the Trust fails to protect patients from the potential increase prevalence of multi-resistant organism then this could lead to avoidable patient harm, financial penalties and reputational issues	3	Screening of high risk patients Performance monitoring, training and audit Strategy (pending)

The Risk Manager is now meeting with all risk owners to move the Trust to a 5x5 risk assessment methodology.

9. Pay Award 2015/16 and Changes to Agenda for Change Redundancy Scheme

The NHS Trade Unions agreed to the implementation of the pay and redundancy changes in the Government recent offer to staff covered under Agenda for Change. This means that there is no risk of further industrial action. For staff on Agenda for Change Bands 8b and below, they will receive a 1% consolidated pay award. Staff above this pay point will not receive this and the non-consolidated payment given last year will be removed. Some small further enhancements have also been made to staff on the lower bands of the pay scale.

For medical staff 2015/16 is the second year of the two year pay award announced in 2014. Doctors will receive either their incremental pay uplift or, for those at the top of their pay scale to either a 1% or 2% non-consolidated (sum dependent upon when they reached the top of their scale).

Changes have also been made to the calculation of redundancy payments. Minimum redundancy will be just under £4,000 (and an earnings ceiling of £80,000 per annum will be used to calculate payments). These payments are not applicable to medical staff at this stage.

10. Recommendations

The Board of Directors is asked to note the report.