

Board of Directors (Public)

Item 4.5

Board Report

Subject: CEO's Report
Date of meeting: Tuesday 28th July 2015
Prepared by: Executive Team
Presented by: Jane Tomkinson, Chief Executive

Data Quality Rating	BAF Ref	Impact on BAF Risk rating
n/a	1-8	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. Listening Into Action (LiA)

We have concluded our Big Conversations at the Trust which took place through May and June. We held 5 sessions attended by nearly 200 staff of all professions. An additional session was held for the Surgical Division during their Audit day in July; this was well attended and gave us important feedback from the surgical body. It also confirmed that a number of clinical themes identified will have repercussions in other areas; i.e. one of the most frequent frustrations from the clinical teams was the lack of beds in ITU/POCCU. Four of the themes will impact this:

- Home for lunch
- Discharge summaries
- Delayed discharges in critical care
- Number of patient's moves post-surgery

A number of quick wins have been identified from the feedback from staff; the following are examples:

- Updating of the staff directory in the intranet
- Use of scrubs instead of uniforms in ITU
- Inclusion of all staff uniforms (including domestics and porters) in electronic wards' dashboard
- Extended EPR log out time from 5 min to 15 min

All 10 LiA Clinical Teams have been confirmed and had their official launch on two sessions held on 21st and 22nd July. This has been the start of the 20 week deadline for delivery of actions.

Regular updates to staff are maintained through the weekly e-bulletin, the LiA intranet page and the quarterly newsletter.

3. 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.	The joint PCI consultant is now in post and we have advertised the joint EP post. Unfortunately there were no suitable candidates so we are aiming to go back out to advert for this post. We are also delivering stress echo sessions at Arrowe Park as part of the SLA. We held a “partnership” meeting at the end of June to discuss progress and potential future developments.
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 providing support to Southport whilst we try to make progress with a more formal partnership arrangement moving forward. A meeting has been arranged with the Southport team in August to agree actions and timescales as part of a “partnership” plan.
St Helens and Knowsley Teaching Hospital NHS Trust	Joint posts	A joint PCI post has been recruited to and there are further discussions to be held regarding further opportunities to develop services. St Helens and Knowsley Teaching Hospital NHS Trust are a partner in our community respiratory tender for Knowsley CCG.
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.	There has been no further update regarding the proposals to set up a PCI service at Warrington and we are still awaiting the “Cardiac” review report from specialist commissioners.
Aintree University Hospital NHSFT	Joint posts, new models of care.	We are working with Aintree as a partner in the tender for community respiratory services for Knowsley CCG and also as part of the Healthy Liverpool program looking at “one” pathway for cardiology patients.
Alder Hey Children’s Hospital	Partnership opportunity with Alder Hey to provide a “Liverpool” model of care for ACHD patients. This	There is a clinical meeting arranged by specialist commissioners for the 21st August which is being

	partnership would also include the Liverpool Women's Hospital and RLBUTH.	facilitated by Professor Huon Gray to try to agree the best solution for the North West to deliver ACHD services as part of the NHS England review.
Royal Liverpool and Broadgreen University Hospital NHS Trust – Upper GI Service Transfer	To transfer Upper GI cancer services to the Royal site.	Agreement has finally been reached to transfer Upper GI services to the Royal campus with specialist commissioners and the transfer will be completed by the end of this financial year. The Royal are also part of the Knowsley community tender partnership bid.
University Hospital South Manchester	Explore areas for potential collaboration.	A meeting has been held with colleagues from UHSM to discuss areas for potential collaboration between our two Trusts.

4. Healthy Liverpool Programme (HLP)

The HLP continues to progress with options for future configuration yet to be finalised.

Following the Board Strategic workshop with Dr Pat Oakley on 23rd June 2015, the Board of Directors will consider the positioning of LHCH and next steps at its meeting in private.

In addition Liverpool CCG held an event on the 10th July some two years after the initial launch of the Healthy Liverpool Programme. The meeting was well attended by clinicians, senior management from all relevant organisations within Liverpool with NHS England also attending. A recent meeting of Chairs and CEOs from representative bodies established the following vision for the programme;

“Acute providers will collaborate in conjunction with Healthy Liverpool and establish centres of clinical, academic and educational excellence. A centralised hospital university teaching campus with strengthened specialist clinical services with networked model of delivery .Joint strategic options analysis between Royal and Aintree is a key cornerstone”

Fiona Lemmens as lead Liverpool CCG clinician identified the following;

Key Principles

- Single service teams
- Delivered in best practice standards
- Local wherever possible
- Eliminate variation

Key Aims

- Best hospital care system
- Right care right place right time
- Safe health care systems financially and clinically sustainable

Added value

- World class research
- Commercial application and opportunity
- Economic and social benefits
- Long term workforce and training solutions

Workshops focused on such issues as key risks, challenges to programme etc. Issues such as primary care and financials etc were deliberately not the focus of the day.

Broad consensus was sought and given on the above with participants broadly in agreement. Next steps were noted as a Strategic direction case to the Liverpool CCG governing body on the 22nd September describing what Liverpool CCG is going to do, plus to each Trust Board in September a similar document. It was noted that this would be a key focus of attention at the Mayoral health summit in November 2015 followed by a Public consultation.

The Healthy Liverpool Hospital Transformation Clinical Assembly on Friday 10th July provided a clear mandate to move forward with fundamental changes to services to ensure that the city has a clinically and financially sustainable hospital system.

It was agreed that a briefing summarising some of the key outputs from the day would be issued to participants, providers, commissioners and partners. In conjunction, find attached a shared vision to transform hospital services, working together in collaboration for a "Single Service City Wide Delivery" model around a Centralised University Hospital Teaching Campus; establishing centres of clinical, academic and educational excellence.



Liverpool Agrees a
Shared Vision to Tran

5. Deanery Visit

The planned postgraduate education enhanced monitoring visit took place on 8th July 2015 and a follow-up letter from the Postgraduate Dean is attached. A management response and action plan is underway.



Liverpool Heart and
Chest Hospital - Sumr

6. Response to Francis Review into Whistleblowing

The Trust's Raising Concerns policy had been revised to ensure it meets the recommendations arising from the Francis review. The Francis report has two over-arching recommendations, 20 principles and 36 specific actions that cover local and national organisations and these have been grouped under five key themes.

These are:

- the need for culture change
- improved handling of cases
- measures to support good practice
- particular measures for vulnerable groups
- extending the legal protection.

The focus of the whole report is on ensuring concerns are dealt with as patient safety issues.

The two over-arching recommendations are:

- a) All organisations should implement the principles and actions in the report in line with the good practice outlined.
- b) The Health Secretary should review progress at least once a year against the actions in the report.

Some of the specific actions task Trust Boards with the need to:

- assess progress in creating and maintaining a culture of safety and learning, ensuring the culture is free from bullying
- encourage reflective practice, individually and in teams, as part of everyday practice
- have a policy and procedure built on good practice
- talk about and publicly celebrate the raising of concerns
- ensure employees have formal and informal access to senior leaders. In this area, it also recommends:
 - one person is appointed by the chief executive to act as a 'Freedom to speak up guardian'
 - an executive director and non-executive director are nominated as individuals who can receive concerns
 - a manager in each department is nominated to receive concerns
 - employees have access to advice and support from an external organisation (eg: a whistleblowing helpline).

In response the Trust has appointed Lucy Lavan, Associate Director of Corporate Affairs to the role of 'Freedom to Speak Up Guardian'. The idea behind the guardian role is that this should be a person who is senior and largely seen as impartial who can offer advice and support to individuals coming forward to raise concerns.

In addition to the formal Raising Concerns policy and process the Trust has signed up to the national Speak out Safely campaign and to date 22 people have come forward to raise their concerns about patient and staff safety using this more informal route.

7. Inquest held on 11.6.15 into the death of Mrs BH on 18.1.13

Eight members of staff from LHCH were called as witnesses; in the event 6 gave oral evidence. The Coroner read statements from the pathologist and from the expert witnesses and recorded the cause beyond that given by the Pathologist, as:

- 1A pulmonary embolism
- 1B deep vein thrombosis (right leg)
- 2 lung adenocarcinoma and coronary artery disease.

The Coroner returned a narrative conclusion which read as follows:

On 10 January 2013 Mrs BH underwent surgery to remove a cancerous lung lesion in the right upper lobe. The surgery was technically successful; however one recognised complication of thoracic surgery in addition to infection is pulmonary embolism. Actions were put in place by the surgical team to minimise the risk of the development of deep vein thrombosis. These were prescription of low molecular heparin, early mobilisation, compression devices and thromboembolism deterrent stocking (TED). All these were used in the post-operative care plan, however, the nursing records confirm that TED stocking were not in place for significant periods post operatively, which was corroborated by Mrs BH's family. It is however unclear given the other venous thromboembolism prophylaxis as to whether this was significant in the development of deep vein thrombosis.

Mrs BH suffered from other co-morbidities including severe significant coronary artery disease. She suffered an arrest on 18 January 2013 however when the chest was opened on embolectomy no clots were found. At 18.30 Mrs BH died. Pulmonary embolism was confirmed by post mortem. It is unclear as to whether this caused the earlier arrest but it did cause her death. Sub optimum nursing documentation could not be shown to play a part in her cause of death.

8. Regulatory Updates

Monitor has published a consultation on proposed changes to its Risk Assessment Framework (RAF). Monitor is proposing these changes to strengthen its regulatory regime to deal with the current financial challenges facing the foundation trust sector, a move prompted

by the DH announcements on value for money and the urgent need to move towards financial balance.

The proposed changes will make it easier for Monitor to take regulatory action, such as launch an investigation, earlier if a foundation trust is in deficit, failing to deliver its financial plan and/or not providing value for money. Monitor is proposing to enable this by:

- Re-introducing two previously used measures: on tracking foundation trust deficits and another on the accuracy of planning;
- Combining a trust's rating on these new measures with its existing continuity of services ratings (COSRR) to produce a new four-level financial sustainability and performance risk rating, with appropriate regulatory responses to each rating level;
- Making two further changes to ensure trusts make sure they deliver value for money by adding a measure within a trust's governance rating and making a change to the accounting officer memorandum.

On 24.6.15 NHS providers and CCGs received a letter from Simon Stevens about changes to the referral to treatment (RTT) waiting time targets. These changes follow a review undertaken by Sir Bruce Keogh, to ensure that all waiting time measures make sense for patients and are operationally well-designed.

Sir Bruce found that the 18 week RTT standard was being measured in three conflicting ways - through admitted, non-admitted and incomplete standards, and that using these three measures results in perverse incentives. The admitted and non-admitted standards essentially penalise providers for treating patients who have waited more than 18 weeks, whereas the incomplete standard, introduced in 2012, incentivises hospitals to treat patients who have been waiting the longest.

Simon Stevens has accepted Sir Bruce's proposal to abolish the admitted and non-admitted measures, using only the incomplete standard as a measure. This change took effect on 24.6.15.

On 3 June Monitor, TDA and NHS England published 'The Success Regime', a whole systems intervention, a guidance document for the new success regime for challenged local health economies. This regime is intended to create the conditions needed in these health economies to overcome the challenges they face, through aligned intervention and support. The regime signifies a shift from focussing solely on institutions to taking a system-wide approach to dealing with challenges.

There remains an emphasis on progressing the Five year forward view through: (1) a financially sustainable basis this year; (2) a redesign of urgent and emergency care provision; (3) focus on prevention; and (4) new ways of working locally and nationally.

Agency staffing is seen as the single largest cause of provider deficits and temporary staffing is first of many areas where muscular action will be taken to reduce costs. Monitor (with DH and the TDA) is developing proposals to support Trusts to adopt best practice in spending on agency staff by:

- applying a ceiling on agency spend by provider;
- applying a cap on maximum rates of agency pay for different types of staff ;
- using agency frameworks .

The new requirements will come into force between July and September.

On 16th July 2015, Jeremy Hunt issued the government's 25 year vision for a patient-led, transparent and safer NHS. Briefings on the 25 year vision will be issued with this month's Board e-pack.

9. Top Operational Risks

There are currently 8 risks rated 12 and above on the corporate risk register, a reduction from the 9 presented at the May Board. The following table summarises the changes since the last report:

Risk Statement	Old Risk Score (Consequences; Likelihood)	New Risk Score (Consequences; Likelihood)	Reason for Change
There is a risk to the delivery of the Q1 2015/16 18 week waiting time standard caused by inadequate capacity, growth in non-elective demand and Consultant illness in Cardiology leading to delayed patient treatment, reduced patient satisfaction, and regulatory breach	15 (5 x 3)	Risk closed. Q2 risk to 18 weeks estimated as 12 (4 x 3)	Achieved Q1. Changes to the 18 weeks reporting regime.
There is a risk to the maintenance of current referral patterns to the Trust caused by failure to meet referrer service expectations leading to reduced activity and reduced income	12 (4 x 3)	8 (4 x 2)	Referrals 7.5% above plan.
There is a risk to the adequacy of staffing to deliver activity caused by lack of proactive workforce planning and lack of personnel to recruit into hard to fill areas leading to inadequate established workforce capacity and overreliance on bank and agency staff Has been combined into a single risk with There is a risk that the Trust is overly dependent upon premium rated staffing sessions and bank & agency staff to deliver its activity caused by inadequate workforce capacity leading to excessive service costs, adverse impact on EBITDA & CoSRR and the potential for patient harm	Both 12 (4 x 3)	12 (4 x 3)	Essentially same risk source - staffing
There is a risk to patient safety Caused by exposure of patients to Mycobacteria from heater cooler units during coronary artery bypass surgery This could potentially cause an slow growing endocarditis infection post-operatively which becomes clinically evident over months or even years. This infection can be fatal.	12 (4 x 3)	5 (5 x 1)	Based upon our past experience, per patient risk is <0.1%

There are two new risks added to the register:

Workforce governance and job planning – as a result of risks identified from the Consultant job plan review conducted by MIAA .

On-going provision of cardiac surgery identified from exploration of the full ramifications of the heater cooler risk described above.

All high scoring risks are presented below:

Description	Key Objective	Date Identified	Inherent Risk	Date Reviewed	Risk Owner	Consequence	Likelihood	Controls	Residual Risk	Target Risk
There is a risk to the delivering of the Trusts 2015/16 cost improvement programme caused by unidentified schemes and slippage leading to an adverse impact on EBITDA and subsequent impact on the Trusts CoSRR	Finance & Value for Money	Feb-15	20	Jun-15	Chief Finance Officer	4	4	---Prevention---Establishment of a Programme Management Office to ensure schemes are robustly defined and delivered---Detection---Creation of CIP steering group chaired by CEO to ensure high executive visibility of progress with schemes---Prevention---CIP plan to ensure sufficient schemes are identified to cover required savings---Detection---Progress meetings with Divisions to ensure delivery---Recovery---CIP contingency reserve to mitigate underperformance against target	16	12
There is a risk to the 2015/16 income to the Trust Caused by potential tariff restructure leading to an adverse impact on EBITDA, CoSRR and the potential to undermine quality of care	Finance & Value for Money	Jan-15	15	Jun-15	Chief Finance Officer	5	3		15	12
There is a risk to workforce governance caused by lack of a job planning policy, lack of assurance around job planning reviews and their timelines, associated activity expected and delivery of said activity together with no central control or consistency of approach leading to inequity, missed productivity opportunities, excess costs	Workforce	Jan-15	15	Jun-15	Medical Director	3	5	---Prevention---Develop a job planning policy and procedures to standardise the process (external consultant)	15	6
There is a risk to the adequacy of staffing to deliver activity caused by lack of proactive workforce planning, lack of personnel to recruit into hard to fill areas and poor recruitment systems and processes leading to inadequate established workforce capacity, overreliance on premium rated sessions and bank & agency	Workforce	Feb-15	16	Jun-15	Director of Strategy and Organisational Development	4	3	---Prevention---In house recruitment service and tracking tool (TRAC) to ensure new staff in post as quickly as possible---Prevention---Development and commencement of implementation of the Trusts workforce plan to ensure workforce capacity matched to demand---Prevention---Staff management oversight by other areas of the Trust to ensure staff deficiencies are identified and filled---Prevention---Detailed workforce plan for each area aligned to activity plan to ensure workforce needs matched to service	12	6
There is a risk that the Trust is vulnerable to an outbreak of CPE infections or wider antibiotic resistance Caused by the admission of infected patients Leading to service disruption, possible ward closures and potential patient harm	Quality, Patient & Family Experience	Feb-15	15	Jun-15	Medical Director	4	3	---Detection---CPE screening of admitted patients from Trusts with history of CPE infections to ensure that all high risk patients are identified---Prevention---Isolation of high risk patients to limit risk of outbreak---Detection---Hand hygiene processes and audits to ensure adherence to good infection prevention practice---Prevention---Close involvement of Infection Prevention Team with admissions to ensure all checks completed and advance warning communicated---Prevention---Education of staff to ensure the knowledge of all who may come into contact with a CPE patient knows what to do---Prevention---Regular patient monitoring to ensure no outbreaks	12	3
There is a risk to the delivery of the Q2 2015/16 18 week waiting time standard Caused by inadequate capacity, growth in non-elective demand and Consultant illness in Cardiology Leading to delayed patient treatment, reduced patient satisfaction, and regulatory breach	Quality, Patient & Family Experience	May-15	20	Jul-15	Chief Operating Officer	4	3	---Prevention---Maximisation of use of internal capacity to ensure optimal local efficiency---Prevention---18 weeks action plan to ensure improvements are coordinated---Detection---Performance meetings to ensure plan being delivered---Prevention---PTL management to ensure each patient being managed appropriately---Detection---Validation of data to ensure patient timelines are accurately reported---Prevention---Outsourced activity to Stoke and South Manchester to reduce demand---Prevention---Timely review and processing of referrals to ensure that the patient pathway is as efficient as possible	12	6
There is a risk to patient safety Caused by inadequate compliance with the sepsis bundle care Leading to untimely delivery of antibiotics to patients with sepsis and the potential for premature mortality	Quality, Patient & Family Experience	Mar-15	20	Jun-15	Medical Director	4	3	---Prevention---Sepsis order set---Detection---Relaunch of sepsis campaign	12	3
There is a risk to ongoing service provision Caused by failure to comply with guidance on decontamination for heater cooler units and failure of said decontamination to eliminate the risk of slow growing endocarditis infections Leading to reduction or even cessation of all surgery at the Trust	Service & Innovation	Jun-15	20	Jun-15	Associate Medical Director - Surgery	4	3	---Detection---Two weekly water sampling for mycobacteria to ensure that possible infection risks are detected---Detection---Air sampling around heater-coolers to ensure that possible infection picked up early	12	6

An electronic risk register tool has now been implemented, and training is underway.

A contract has been placed with Datix to replace the current risk management system.

10. Recommendations

The Board of Directors is asked to note the report.