

**Board of Directors (Public)****Item 4.2**

**Subject:** CEO's Briefing  
**Date of meeting:** 20<sup>th</sup> October 2015  
**Prepared by:** Executive Team  
**Presented by:** Jane Tomkinson, Chief Executive

**Board Report**

Data Quality Rating	BAF Ref	Impact on BAF Risk rating
n/a	1-8	None

**1. Introduction**

This briefing paper is an update of the CEO's regular report to the Board of Directors.

**2. 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 back out to advert for this post with a plan to interview on 19 <sup>th</sup> November. WUTH have recruited two Cardiologists and are also looking to recruit to as joint community post with St Georges. Relationship visit held on the 8 <sup>th</sup> October and good progress has been made with the joint action plan.
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 more formal partnership arrangements. We have two draft job descriptions currently being approved and finances agreed.
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 service 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 community respiratory service 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 partnership would also include the Liverpool Women's Hospital and RLBUTH.	We are submitting our proposal to deliver the North West ACHD service by 9 <sup>th</sup> October 2015. We then have the next national meeting on the 19 <sup>th</sup> November.
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 service.
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.
Knowsley Contract	Provision of Community Respiratory Services Tender	The Trust in partnership with Aintree, the Royal and Whiston hospitals has won the tender to deliver the new enhanced respiratory service. This new service is an extension to the previous COPD service LHCH has delivered. The new contract runs for 5 years with the chance of a further extension of two years.

### 3. Healthy Liverpool Programme (HLP)

Over two years of what has culminated in the production of a document which was reviewed by Liverpool CCG's Governing Body at its meeting of 29<sup>th</sup> September 2015. The document seeks to describe the overarching Healthy Liverpool Model; set out the five core programmes and ultimately seek approval to progress the strategic direction case.

The 5 core programmes are:

- Living well
- Digital Care & Innovation
- Community Services
- Urgent Care
- Hospital Services

A second Mayoral summit is planned for 16<sup>th</sup> November 2015 prior to an intense period of public engagement and pre-consultation between January to May 2016.

Liverpool Heart and Chest Hospital has been actively engaged in all relevant work streams and has contributed to the document. Of key relevance is the hospital service chapter (renamed previous 'realigning hospitals') which aims for 'single service, city wide delivery'. Modernising cardiology services to a single city wide collaborative delivery model is seen as an enabler and is very much in line with our Vanguard thinking and plans. The overall aim for 'a centralised university teaching hospital campus with a single service city wide delivery through centres of academic, clinical and service excellence', is very clear in its message and Liverpool Heart and Chest Hospital must be cognisant of this in its future thinking. The future vision for centralised cancer services is also of relevance given our expertise and outstanding outcomes in the field of thoracic cancers.

## 4. Regulatory Update

### 4.1 Monitor and TDA Nursing Agency Spend rules

Monitor and the TDA have jointly launched a set of rules for nursing agency expenditure. These, together with a 'ceiling' rate for each trust take effect from 1st October 2015. The new rules cover: -

- An annual ceiling for total nursing agency spend for each trust
- Mandatory use of approved frameworks for procuring agency staff

These rules apply to all NHS Trusts and Foundation trusts receiving interim support and/or those in breach of their licence for financial reasons. All other FTs are strongly encouraged to comply. Liverpool Heart and Chest Hospital has been set an annual ceiling limit of 3% as a total of registered nursing staff spend.

The trust has been asked, and has submitted a profile of its anticipated spend across the rest of the financial year.

## 5. Legal Update

### III Treatment and Neglect

New legislation relating to the offence of **ill treatment** or **neglect** came into force on 13<sup>th</sup> April 2015

– S 20 Criminal Justice and Courts Act 2015

Applies to:

- Individuals employed (paid work) to provide healthcare (physical health or mental health) to adults and children; and social care to adults
- Supervisors and managers of individuals providing such care
- Deliberate or reckless acts – not genuine errors

If an individual is found guilty of an offence under this section of the Act they are liable to up to 5 years imprisonment and / or a fine.

Providers can receive substantial fine if they are unable to evidence appropriate oversight – e.g. policies, procedures, training, audit, and cultivation of a positive culture / values and behaviours.

It is possible that providers may see an increase in police investigations arising from complaints in relation to this new offence.

## **EU Data Protection Reform**

Significant reform is underway and sanctions for breach (and imposed remedies) will be significant.

The Trust (as a data processor) must designate a Data Protection Officer – there will be specific requirements relating to this role which may go beyond the scope of traditional Information Governance Officer role

Breach notification will be compulsory (already the case for NHS Providers).

Rules around records and documentation are likely to go beyond those set out in current IG Toolkit – new definitions and principles; grounds for processing data (and consent); fair processing notices; subject access and improved rights. Privacy impact assessments required.

In readiness Trusts are advised to know what data they hold and on what lawful basis; understand whether they are a data controller or data processor and ensure that current rules are being followed in relation to the retention and disposal of documents.

## **6. Deanery Visit**

The planned postgraduate education enhanced monitoring visit took place on 8<sup>th</sup> July 2015 and a follow-up letter from the Postgraduate Dean is at Appendix 2. The next planned Deanery visit will take place on Thursday 22<sup>nd</sup> October 2015. A management response and action plan is in place and a lot of progress has been made.

## **7. Consultant and Junior Doctors Contract Reform**

The Government has set out clear direction for reform of the consultant and junior doctors' contracts. The Health Secretary met with the BMA Junior Doctors Committee on the 25<sup>th</sup> September 2015 and has since given a number of key assurances to them on the impact of the proposed reforms. The main assurances are that this is not a cost cutting exercise, that changes will be cost neutral, night work and Sunday will continue to attract unsocial hours payments, that some pay protection will be offered if the BMA return to the negotiating table and that the contract will not introduce longer working hours.

The junior doctors have been asked for a decision by 14<sup>th</sup> October 2015 as to whether they will return to talks; otherwise the new contract will be imposed from August 2016.

- The BMA had agreed to re-enter negotiations about the implementation of a new consultant contract for implementation in April 2016 (moving existing consultants across by 2017).
- The main aim of the government is reform the contracts to meet the need for expanded 7 day services to reduce variations in patient care and outcomes. In particular: -
- Expanding seven-day services to address the 'weekend effect' on patient outcomes
- The proposals are being viewed as a total package of reform across the two contracts.
- Changes are required to the time-served, mainly annual incremental progression in both contracts.
- The 'night window' for out-of-hours work should start at 10pm (currently 7pm) and that a common definition should be applied across all staff groups.

- The Doctors and Dentists Pay Review Body (DDRB) supports the proposed approach to the pay package for juniors. Whilst it noted that the rates for unsocial hours and other elements were for the parties to agree, it also noted that total pay for juniors compares favourably with comparator groups and that given the cost-neutral pre-condition for negotiations, that position will continue.
- Contractual safeguards are needed to ensure that consultants and junior doctors are not expected to work excessive hours, and can maintain a reasonable work-life balance.
- DDRB considers that removal of the opt-out is most important and significant.
- Scope for progressing some elements of consultant reform at different speeds, including early removal of the consultant opt-out.
- The DDRB supports the continuation of national Clinical Excellence Award (CEAs). They believe that given the separation of local CEAs (to be reformed as performance pay, or payments for excellence), the value of national CEAs will need further consideration.

## **8. Key findings in the wider NHS Pay Review Body report covering staff on Agenda for Change contracts**

There will also be further work on the Agenda for Change (A4C) pay system. The A4C Pay Review Body has carried out its review of the contract and reported its findings:-

- The Agenda for Change (A4C) pay system was not viewed as a barrier to the delivery of seven-day services.
- More work is needed to understand how future services would be delivered, the workforce implications and the transitional arrangements to a new way of working.
- Contract reform should work for staff and patients and that any reform of premium pay should not be done in isolation, but as part of a wider package of reform.
- NHS premium pay rates are not out of line with comparator industries, but that there is a case for some adjustments to the unsocial hours for which plain time would apply. For example, evening plain time extending from 8pm to 10pm. It was noted that some sectors had also extended plain time working to include Saturday working.
- Reform of unsocial hour's payments should be considered as part of the wider review of the AfC pay, terms and conditions, which would include reform of incremental pay progression so that the link between pay and performance is strengthened.
- Trade unions have been asked to enter into formal negotiations with NHS Employers to agree a balanced package of affordable proposals in line with the earlier pay deal agreement, to begin implementation from April 2016
- Negotiations will build on the 2013 agreement for A4C pay progression and seek to fully remove the practice of automatic annual incremental progression from the NHS pay system.
- It is anticipated that the 1 per cent per year public sector pay restraint budget announcement is intended to be a cap of 1 per cent on total pay increases (ie. including incremental pay costs), and the pay review body will be asked how this should be applied.

The Trust has responded to the recent Monitor request for information about out of hours cover and is progressing with the implementation of 7 day provision as appropriate to the range of services delivered at LHCH.

## **9. Annual Staff Survey and Flu Campaign**

The 2015 survey has been launched. All staff have received an electronic log to complete the survey on line this year. This is following feedback that staff would prefer this for ease and confidentiality.

The 2015 flu campaign has also be launched.

## **10. Top Operational Risks**

There are currently 8 risks rated 10 and above on the corporate risk register, the same number as presented at the July 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 workforce governance caused by lack of a job planning policy, lack of assurance around job planning reviews and their timeliness, 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	15 (3 x 5)	6 (3 x 2)	Development of job planning policy and delivery of training to Consultant medical staff.
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	12 (4 x 3)	8 (4 x 2)	Purchase of two new heater coolers, with a commitment to buy more from next year's capital allocation.
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	10 (5 x 2)	5 (5 x 1)	Highly unlikely that new guidance for in year change will be released so late in the year.

There are three new risks added to the register:

1. There is a risk to the delivery of community services caused by the lack of an integrated electronic patient required for using in the community. Score **15**.
2. There is a risk to quality of care and effective clinical decision making caused by lack of assurance of medical secretariat administrative processes. Score **12**.
3. There is a risk to continuing cardiac surgery by using the fibrillation lead devices caused by the device not being properly documented (CE marked) by the company. Score **12**.

The following risks remain static:

Cost improvement programme	<b>16</b>
Workforce planning	<b>12</b>
Antibiotic resistance	<b>12</b>
18 weeks (Q3)	<b>12</b>
Sepsis bundle	<b>12</b>

Full detail of the risks together with all other high scoring risks are presented in the table attached in the appendix. The table also triangulates corporate risks with the associated (driver) risks coming up from the Divisions. These are presented in the columns to the right hand side of the table, and are colour coded according to source Division. The key is at the bottom of the table.

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

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

#### 4. Recommendation

The Operations Board is asked to note the report.

Description	Key Objective	Date Identified	Inherent Risk	Date Reviewed	Risk Owner	Consequence	Likelihood	Controls	Residual Risk	Target Risk	Driver 1	Driver 2	Driver 3	Driver 4
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	Oct-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---Detection---Deployment of external due diligence reviews (Radiology) to ensure that additional efficiencies are being explored and implemented (if favorable)	16	12	There is a risk to Critical Care finances, caused by the Unit being under resourced in both pay and non-pay for the activity and level of care being carried out and the inappropriate use of level 3 beds due to delayed discharge hours, leading to failure to achieve CIP, potential for EMSA breach fines, loss of level 3 income and going over the Unit set financial budget. <b>Score 12</b>	There is a risk to the delivering of the Division's 2015/16 cost improvement programme caused by unidentified schemes and slippage leading to lack of financial balance, reduced contribution to Trust position, leading to a potentially adverse impact on EBITDA and subsequent impact on the Trusts CoSRR. This potentially leads to a reduction in service delivery and/or workforce within the Division. <b>Score 12</b>		
There is a risk to the delivery of community services, with an associated risk of service inefficiencies and increased cost/rework caused by the lack of an integrated electronic patient required for use in the community leading to the duplication and fragmentation of patient records stored on paper and rework and manual work arounds, as well as the inability to fulfill current or anticipated CCG service specifications for community services	Service & Innovation	Jul-15	15	Sep-15	CCIO / Caldicott Guardian	3	5	---Prevention---Maintenance of manual paper records across individual community services to ensure that accurate clinical records for all patients are maintained---Prevention---Manual updating of records or service requests when back on the LHC site to ensure accurate clinical records for all patients are maintained	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	Sep-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---Prevention---Development and commencement of implementation of the Trusts People Strategy to ensure that future capacity and skills matched to demands---Prevention---Simplified vacancy control process to ensure that to ensure vacant positions are filled quickly with minimal bureaucracy---Prevention---Oversight from new Head of Recruitment to ensure that to ensure all workforce recruitment and retention processes working optimally---Detection---Deep dives into exit interview data from areas with highest turnover rates to ensure that to ensure remedial action is being taken based upon feedback from leavers---Prevention---Engagement with local job fairs to ensure that we are providing opportunities to work for us to our local population	12	6	There is a risk to the safe staffing of ward and theatre areas Caused by the inability to recruit appropriately trained members of staff leading to the use of agency nursing staff and the possibility of activity being impacted if appropriate staff numbers can not be recruited. <b>Score 12</b>	There is a risk to running of core and additional theatres lists Caused by the lack of perfusion staff leading to the possibility of cancelling core operating lists and the inability to run additional lists. <b>Score 12</b>		
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 or the development of infection in in-patients leading to service disruption, possible ward closures and potential patient harm	Quality, Patient & Family Experience	Feb-15	15	Sep-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---Detection---Regular patient monitoring to ensure no outbreaks	12	3				



Description	Key Objective	Date Identified	Inherent Risk	Date Reviewed	Risk Owner	Consequence	Likelihood	Controls	Residual Risk	Target Risk	Driver 1	Driver 2	Driver 3	Driver 4
There is a risk to the delivery of the Q3 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	12	Oct-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 the provision of timely care for patients and the delivery of RTT waiting time guarantees, with a consequential impact upon the reputation of the Trust Caused by limited capacity for general anaesthetic support to a number of routine lists across the Medicine Division. This is compounded by increases in demand for GA support as activity increases. Leading to inefficiencies and delays in patient pathways, and contributing to the backlog of patients waiting in excess of 18 weeks from referral to treatment. This has financial and reputational consequences to the Trust, as well as impacting upon patient experience. <b>Score 12</b>	There is a risk to the delivery of the 18 week access target Caused by inadequate capacity available Leading to delayed patient treatment, unsatisfactory patient experience and failure of a regulatory standard. <b>Score 12</b>	There is a risk to timely patient care within the Adult Congenital Heart Disease service, with an associated risk that some patients may have care delayed or not provided. This is a safety risk and can adversely impact upon the reputation of the organisation. Caused by imbalance between demand for the service (and new transitions each year from paediatric services) and the capacity available within the outpatient/diagnostic elements of the service. Leading to delays in providing new and follow-up care. <b>Score 12</b>	There is a risk to the delivery of the 18 week access target Caused by inadequate capacity available Leading to delayed patient treatment, unsatisfactory patient experience and failure of a regulatory standard. <b>Score 12</b>
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 poor quality care	Quality, Patient & Family Experience	Mar-15	20	Oct-15	Medical Director	4	3	---Prevention---Development and implementation of a sepsis order set to ensure consistency in the delivery of sepsis care---Detection---Relaunch of sepsis campaign (training package) to ensure staff have necessary knowledge to recognise and treat sepsis effectively and timely---Prevention---Empower non-physician prescribers to administer the first dose of antibiotics to ensure that antibiotics are delivered as quickly as possible---Recovery---Electronically flag patients in receipt of a sepsis order to ensure that patients can be easily identified for follow up, ensuring treatment is complete	12	3				
There is a risk to continuing cardiac surgery if using the fibrillation lead devices as mentioned in the field safety notice Caused by the device not being properly documented by the company for its purpose leading to potential for some cardiac surgeons being unable to perform surgery. Leading to cancellation of cardiac surgery with significant consequences for patients.	Quality, Patient & Family Experience	Jun-15	12	Sep-15	Associate Medical Director - Surgery	4	3	---Detection---Contact made with MHRA for guidance - they have confirmed that as there have been no reported patient safety issues for the leads and the impact of not using them, it is for each trust to risk assess the continued usage. There are currently no alternative suppliers that can be sourced in the world. Contact has been made with other specialist units who are continuing to use as there is no alternative. to ensure that patients continue to undergo cardiac surgery.	12	3				
There is a risk to quality of care and effective clinical decision making Caused by lack of assurance of medical secretariat administrative processes in relation to clinic letters and discharge summaries not being uploaded to EPR and missing documentation leading to potential harm or clinical negligence	Quality, Patient & Family Experience	Sep-15	14	Oct-15	Patient Administration Manager	3	4	---Detection---Review and audit of documentation to identify the cause of the problem, whether letters are being returned to the medical secretariat in a timely manner to allow uploading to take place and to identify if any individuals are not following processes. Processes and quality assurance and compliance to be provided to IMandT PB and Risk Management Committee. Action Plan to ensure that all patient correspondence is uploaded to EPR for all patients in a timely and accurate manner to support effective and safe clinical decision making	12	2				
<b>Key:</b>														
Clinical Services														
Medicine														
Surgery														