Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE OPERATIONS AND PERFORMANCE COMMITTEE (OPC)
MEETING HELD ON WEDNESDAY 28 AUGUST 2024 ON MS TEAMS

Present:
Mr J Worrall - OPC Chair, Non-Executive Director
Mr A Furlong - Medical Director
Dr A Haynes MBE - Non- Executive Director

Non-Voting Members
Mr M Brearley - Interim Chief Financial Officer.
Ms D Burnett – Director of Midwifery
Ms S Favier - Deputy Chief Operating Officer
Ms J Frake-Harris – Interim System Director for Urgent and Emergency Care
Prof A Garcea - Associate Non-Executive Director
Ms H Hendley - LLR Director of Planned Care
Ms S Nancarrow - Associate Director of Operations – Cancer
Ms S Taylor - Deputy Chief Operating Officer

In Attendance:
Ms L Fletcher – Head of Operations, ITAPs
Mr R Manton – Head of Risk Assurance
Ms A Moss - Corporate and Committee Services Officer

RESOLVED ITEMS

90/24 WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr J Melbourne, Chief Operating Officer, and Ms J Hogg, Chief Nurse.

91/24 CONFIRMATION OF QUORACY

The meeting was quorate.

92/24 DECLARATION OF INTERESTS

There were no declarations.

93/24 MINUTES

Resolved – that the Minutes of the meeting of Operations and Performance Committee held on 31 July 2024 (paper A refers) be confirmed as a correct record.

94/24 MATTERS ARISING

The Action Log was received.

Resolved – that the Operations and Performance Committee matters arising log (paper B refers) be received and noted.

95/24 KEY ISSUES FOR ASSURANCE

95/24/1 Cancer Operational Performance Report

The Associate Director, Cancer, provided detail on the Trust's cancer performance (paper C refers). This item was considered in mitigation of BAF risk 2 – 'Demand overwhelms capacity and delays

access to services, resulting in failure to meet national standards for timely urgent, cancer and elective care'.

The Committee noted a continued rise in cancer referrals, with a 5.3% increase for the year to date. The Trust had achieved the Faster Diagnosis Standard (proportion of patients having been diagnosed within 28 days of being referred for a suspected cancer) for the tenth consecutive month and was on track to do so for August 2024. Performance against the standard for patients commencing treatment within 62 days of a confirmed diagnosis was 58.1% in June 2024 against the standard of 70%. This was a deterioration of 1.1% from plan and driven by the backlog of patients awaiting treatment. At the end of July 2024, 429 patients had waited over 62 days (against the plan of 346). There was no one tumour site driving the variance from plan and all specialities were being supported in tracking and improving performance.

The criteria for the tiering status had changed and it was likely that the Trust would be in Tier 2 which would entail greater oversight from NHSE.

At the end of July 2024 there were 103 patients waiting over 104 days to commence treatment, 16 ahead of plan. The Trust's performance was similar to that of other NHS trusts in the Midlands.

The actions to improve would focus on the 31-day performance. This was predominantly driven by limited capacity for radiotherapy and the Trust would be very reliant on mutual aid until the fifth linear accelerator (linac) was commissioned. There would be a report to the next meeting on the impact of low fractionation for radiotherapy. Noting the limited actions that could be taken in the short term, there were actions the Trust could take with respect to surgery and drug treatment. There had been an audit of 31-day performance which identified good practice for breast cancer patients in booking pre-operative assessment and date for treatment. It was thought that as this was shared across tumour sites there would be a clearer picture regarding capacity for pre-operative assessment and theatres.

Dr A Haynes, Non-Executive Director, expressed concern about the delays for kidney patients. The Associate Director reported that an additional surgeon was due to start at the Trust and this would increase capacity. However, as the backlog had grown, she undertook to report back to the next meeting. **AD**

It was noted that some of the patients whose waiting time had 'breached' the target had been reluctant to travel to Lincoln or Nottingham for radiotherapy. Patients were offered support with travel and if necessary, the provision was being reallocated to other patients on the waiting list. Whilst this did not help the number of breaches it meant that the capacity was used.

The Chair summarised the discussion and hoped that the Trust would achieve the target of no patients having waited over 104 days for treatment due to capacity issues. He highlighted the importance of getting the backlog down.

<u>Resolved</u> – that (A) the report be received and noted, and

(B) a further report be made on the delays for kidney cancer. **AD**

95/24/2 <u>Elective Care (RTT and DM01)</u>

The Deputy Chief Operating Officer (Ms S Favier) provided an update on the recovery of elective care, highlighting areas of risk and noting actions (paper D refers). This item was considered in mitigation of BAF risk 2 - Demand overwhelms capacity and delays access to services, resulting in failure to meet national standards for timely urgent, cancer and elective care.

The Committee noted the Trust's progress in achieving recovery in elective care. At the end of August 2024, it was likely that three patients would have waited over 78 weeks for treatment. The circumstances for each patient were noted and it was acknowledged that the breach in waiting time could not have been avoided. Whilst the number of patients in this cohort was going down it was not as quickly as hoped. However, there were issues around patient choice and complexity of case which impacted.

At the end of July 2024, 161 patients had waited over 65 weeks for treatment which was an improved position. The Trust benchmarked well against peer trusts. The Trust had forecasted to NHSE, that no patients would have waited over 65 weeks by the end of September 2024. This would need to be revised as it was likely to be between 20-50 patients. The speciality most at risk was Ear, Nose and Throat (ENT).

The Deputy Chief Operating Officer highlighted a further risk as remedial work was needed for ventilation for a theatre used for ophthalmology. In addition, a fire safety risk had been identified in relation to Jarvis Building at Leicester Royal Infirmary (LRI) and should the building be closed, the impact would be significant on clinic capacity. The age of the theatres and outstanding maintenance issues was impacting on operational performance.

Prof A Garcea, Associate Non-Executive Director, asked whether, when theatres needed to be closed, whether the activity could be located elsewhere. The Deputy Chief Operating Officer noted this was not possible for theatres at LRI due to the complexity of the surgery and requirement for on-call teams and High Dependency Unit. Whilst there was scope for the theatres at the Leicester General Hospital (LGH) the constraint was the need for inpatients beds. The LLR Director of Planned Care noted that the System was considering how best to use the community theatres. Whilst some of the more straightforward cases could be treated in the community hospitals, they were often added to the LRI lists as 'fillers'. The intention was to bring in-house the cataract operations currently undertaken in the independent sector.

The Medical Director reflected that having worked in the Trust many years, there had been plans to upgrade the theatres, and in particular, to improve ventilation and create 'decant' theatres. However, there had not been the capital funding. Whilst, the East Midlands Planned Care Centre would increase capacity, issues such as the potential closure of Jarvis Building highlighted the consequences of underfunding routine maintenance. The Deputy Chief Operating Officer added that the inability to decant activity to other theatres increased the costs of maintenance as the ventilation for theatres was linked; to repair one theatre meant taking two theatres out of action.

The Deputy Chief Operating Officer reported that performance in the standard for 52 weeks wait for treatment remained stable. The previous week there had been 1,964 patients waiting over 52 weeks which was better than planned and forecasted for continued improvement. Paediatric ENT remained an outlier and paediatric care was impacted by constraints on the paediatric bed base rather than theatre capacity. It was noted that this was A particular concern as the increased demand over winter was usually experienced earlier in the year for paediatric care.

The total waiting list for treatment was continuing to grow and the report gave a breakdown by speciality. Prof A Garcea, Associate Non-Executive Director, noted that NHSE was looking at the number of referrals per person and wondered if that could explain some of the increase. The Deputy Chief Operating Officer noted that the Trust reviewed duplicates and the number of referrals per person was something she would be interested in reviewing. Dr A Haynes, Non-Executive Director, observed that the increase in the waiting list for rheumatology was quite striking.

The Deputy Chief Operating Officer directed the Committee to the report which listed the actions to improve elective recovery and asked the Head of Operations to provide an update on the plans to improve pre-operative assessment.

The Head of Operations noted that individual specialties were responsible for pre-operative assessment and there was considerable variation in practice. There was a project to centralise and standardise practice to improve theatre utilisation and productivity. The project had referenced the core requirements as set out by 'Getting it Right First Time'. Whilst there had been significant progress made, the project had stalled and there was a need for a management of change process to centralise teams and provide enough physical clinical and administrative space to support staff. There would be a report to the Trust Leadership Team seeking investment funding as previously agreed within the business case that was approved but not added into budgets. The Medical Director added that the Trust had started with a very mixed picture, with some specialities operating a gold standard and others with minimal provision. Whilst the Clinical Management Groups had signed up initially there was some resistance to change. The intention was to standardise practice where possible and allow bespoke arrangements where clinically justified. There was a need to identify a funding source as the

initiative had used short term elective recovery funds. The service needed to be embedded as business as usual. Whilst there was confidence that the project would achieve its aims to improve quality of care and productivity, the project had encountered some challenges which needed to be overcome.

Dr A Haynes, Non-Executive Director, acknowledging the value of the project asked whether there were interim improvements that could ensure momentum. The Head of Operations noted that whilst a centralised team was the right thing to do, a phased approach would be explored with the Clinical Management Groups.

Prof A Garcea, Associate Non-Executive Director, asked about how the pre-operative assessment project sat within the wider context of health promotion and public health. She proposed greater collaboration with Primary Care Networks which had health and wellbeing coaches. The Deputy Chief Operating Officer agreed and considered that the Trust could be better at linking in with primary care. She cited the example of the Trust listing patients with uncontrolled diabetes. The consultancy firm Bain was supporting the Trust in better utilisation of clinics. There were initiatives to support the recruitment and retention of administrative staff which would help. **DCOO**

The Committee asked for an update on pre-operative assessment early in the new calendar year.

The Associate Director briefed the Committee on performance of diagnostic services. The overall size of the waiting list had increased to 23,752. At the end of July 2024, 5,091 patients had waited over 6 weeks for a diagnostic test (an increase from 4,534 the previous month) of which 1,848 were over 13 weeks.

The LLR Director of Planned Care reported on the Planned Care Partnership noting that the Alliance would be renamed 'UHL in the Community'; that the use of community theatres was under review; and the Hinkley Community Diagnostic Hub was due to open in January 2025. She reported that the University Hospitals of Northampton and UHL Elective Co-ordination Group was working well and sought to make best use of shared capacity and improve productivity.

Resolved – that (A) the report be received and noted, and **DCOO**

(B) that a further update on pre-operative assessment be reported in the new year.

95/24/4 Urgent and Emergency Care

The Committee was briefed on developments in Urgent and Emergency Care (UEC) (paper E refers). This item was considered in mitigation of BAF risk 2 – ' Demand overwhelms capacity and delays access to services, resulting in failure to meet national standards for timely urgent, cancer and elective care'.

The Interim System Director for Urgent and Emergency Care reported on work with system partners to improve flow in and flow out of the hospital. There had been 'system quality huddles' which considered individual cases and shared learning. There would be a LLR System Winter Workshop to identify the actions that would have the most impact and ensure that the priorities for system partners were understood. MADE events have been implemented on a weekly rolling basis.

The Deputy Chief Operating Officer (Ms S Taylor) reported on the performance of UEC which had been very challenged in July and improved in August 2024.

There had been an increase in attendances at the Emergency Department (ED) and hospital admissions in July 2024. The performance against the standard for four-hour waits in ED remained on track. Ambulance handovers for July 2024 had been challenging with an average handover time of 38.11 minutes. One patient had waited over eight hours on an ambulance in July 2024. Performance against the 12-hour wait in ED remained challenged and there were issues with stroke capacity. The average length of stay had slightly increased and improvement actions were in place.

Work was progressing to agree the location for an Urgent Treatment Centre in Leicester City, following which the workforce and infrastructure required would be defined.

There were two pilots recently agreed by the Trust Leadership Team. The first was for a Frailty Same Day Emergency Care service. The second was a weekend discharge pilot. This drew on the experience from the industrial action and value of having senior decision-makers at the front door of the Emergency Department.

The work down to improve hospital discharges was noted. The number of incomplete discharges had increased which was linked to the work to embed the new transport provider EMED and the number of rebeds we experienced. However, performance had recently improved. The MADE event with system partners had been useful in addressing complex pathways and there had been learning across departments such as pathways for homeless patients. There was a focus on the length of stay. The pathway analysis following on from the work with the University of Leicester was highlighted and the system challenge around 0 Length of Stay was noted. The coding did not help with the analysis, and this would not change until the next version of Nervecentre was rolled out.

The UEC ambition for ED waiting times was noted. The plan was to reduce the initial time to be seen from 22 to 15 minutes and the time patients waited for the ED assessment from 99 to 80 minutes. This was work in progress and further updates would be presented.

Dr A Haynes, Non- Executive Director, asked how the Trust benchmarked for Same Day Emergency Care and how the new frailty service would link into community services. The Deputy Chief Operating Officer considered that the Trust was 'in line' but agreed to share the data and noted that links with the community were being made. The Medical Director highlighted the need to make sure this was captured in the pilot. Prof A Garcea, Associate Non-Executive Director, asked about system and social literacy to ensure clinicians were aware of the services available. She also noted the need for clinical and managerial leadership and for staff to understand the 'lived experience'. The Deputy Chief Operating Officer noted the point and that the Trust was following the lead from Barts Hospital and the REACH model which set up a central point for knowledge for clinical navigation. This would be piloted for the winter. The Medical Director noted that Lee Walker had been appointed to the Deputy Medical Director post with responsibility for UEC, consequently this work and support for frailty would be ramped up. **DCOO**

The Interim System Director for Urgent and Emergency Care highlighted the need for personalised care. She considered that patients should be empowered to think about their future needs and agree a care plan to avoid unwanted admissions.

Resolved – that (A) the report be received and noted, and

(B) to share SDEC benchmarking data with Dr A Haynes, Non-Executive Director. **DCOO**

96/24 ITEMS FOR NOTING

96/24/1 Integrated Performance Report M4 2024/25

Resolved – that the report be received and noted.

97/24 CONSIDERATION OF BAF RISKS IN THE REMIT OF OPERATIONS AND PERFORMANCE COMMITTEE

97/24/1 BAF Report

The Committee reviewed strategic risk 2 on the BAF around failure to meet national standards for timely urgent and elective care which was aligned to the Committee and its work plan. The Committee noted the updates in the month in red text and the changes in controls and the next steps. The Committee agreed that the risk score should remain at 20.

The Head of Risk Assurance noted that the risks around the backlog of estate maintenance, discussed earlier in the meeting, were reflected on the Risk Register.

Resolved – that the report be received and noted.

98/24 ANY OTHER BUSINESS

There was no other business.

99/24 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF OTHER COMMITTEES

Resolved – that there were no items to be highlighted for the attention of other Committees from this meeting of OPC.

100/24 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following issues be highlight to the Trust Board for information:

- **Cancer Operational Performance** – to note performance was going in the right direction
- **Elective Care** - to note the importance of the pre-operative assessment project
- **Urgent and Emergency Care -** to note the introduction of the two pilots.

101/24 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the OPC be held on Wednesday 25 September 2024 from 10.00 am (virtual meeting via MS Teams).

The meeting closed at 11.28 am Alison Moss - Corporate and Committee Services Officer

Cumulative Record of Members' Attendance 2024/25

Voting Members

Name	*Possible*	*Actual*	*% attendance*
J Worrall (Chair) *(until September 2024)*	5	5	100
A Haynes	5	5	100
B Patel *(until end June 2024)*	3	0	0
J Melbourne	5	4	80
A Furlong/ J Hogg	5	5	100

Non-voting Members

Name	*Possible*	*Actual*	*% attendance*
R Mitchell	5	0	0
J MacDonald *(until June 2024)*	3	0	0
A Moore *(from July 2024)*	2	0	0
M Brearley *(from June 2024)*	2	1	50
L Hooper *(until June 2024)*	3	0	0
H Hendley	5	3	60
S Favier	5	4	80
S Taylor	5	5	100
S Nancarrow	5	5	100
R Briggs	5	0	0
J Frake-Harris *(from July 2024)*	2	2	100