Trust Board Paper J1

Meeting title:	Public Trust Board					
Date of the meeting:	13 June 2024					
Title:	**Escalation Report: Operations and Performance Committee 29 May 2024 - Public**					
Report presented by:	Jeff Worrall, Operations and Performance Committee Non-Executive Director Chair					
Report written by:	Alison Moss, Corporate and Committee Services Officer					
	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Not applicable					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Yes, The BAF Risk 2 around Urgent and Emergency Care, Cause: Demand overwhelms capacity and delays access to services; Event: Failure to meet national standards for timely urgent and elective care.

Impact assessment
• N/A
Acronyms used:

1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Operations and Performance Committee (OPC) and escalate any issues as required.

2. Recommendation

That the report be noted.

3. Summary

OPC met on 28 May 2024. The meeting was quorate and considered the reports below.

4. Discussion Items

4.1 Business Intelligence and Information Strategic Direction *(in mitigation of BAF Risk 02)*

The Committee noted the key initiatives and priorities of the Business Intelligence and Information Team. In addition to business as usual, the priorities for the year ahead would include the replacement of the Patient Administration System and the data platform. In the medium term, this plan would be considered alongside the partnership with University Hospitals of Northamptonshire and the digital strategy. The Committee asked for a further update as the strategy was progressed, to include examples of how any investment could benefit the Trust.

4.2 West Midlands Senate Review of Cardio/respiratory and Medicine Acute Services *(in mitigation of BAF Risk 02)*

The Committee was updated on the response to the review undertaken by the West Midlands Clinical Senate with respect to Cardio/respiratory and Medicine Acute Services at the Trust. The Respiratory Support Unit and ward 15A had opened which increased respiratory capacity, reduced the time patients waited in the Emergency department. A pilot study was underway which meant that medicine colleagues provided more cover and freed up cardiologists to in-reach into the Clinical Decisions Unit. This had increased the number of patients discharged to outpatients or virtual wards rather than be admitted.

4.3 Cancer Operational Performance Report *(mitigating BAF Risk 2)*

The Committee reviewed cancer performance. In March 2024 the Trust achieved the Faster Diagnosis Standard (FDS) standard. The targets for 31 and 62 days were not met although the performance for 31 days had improved. Indicative data showed a deterioration for all three standards in April 2024 which reflected the national picture. This was partly due to the increase in referrals and a significant amount of annual leave being taken. The capacity within radiotherapy meant that performance was particularly challenged and waits for breast and prostate patients a concern. Mutual aid was being sought. Commissioning the fifth linac at the end of 2024/25, which was pending Trust Board approval, would increase capacity.

The objectives for 2024/25 are to deliver 77% FDS each month; increase the numbers of cancers diagnosed within the FDS standard, reduce the number of patients waiting more than 62 days to less than 228 and the number waiting more than 104 days to less than 45, by March 2025; and striving to deliver 70% confirmed diagnosis and start of treatment within 62 days by March 2025.

The report provided a review of urgent suspected cancer referrals by ethnicity and deprivation score. The data raised questions for further exploration. The Early Diagnosis Cancer Summit had agreed an action to increase education, awareness, and target local communities about the signs and symptoms of cancer.

4.4 Elective Care and Diagnostic Services (RTT and DM01) (mitigating BAF Risk 2)

The Committee was briefed on waiting times for elective care and diagnostic services and actions to improve performance.

At the end of April 2024, 12 patients had waited 78 weeks or more. The forecast was for zero patients by the end of June 2024, but this was not without risk. At the end of April 2024, 225 patients had waited 65 weeks or more which was higher than planned. The forecast was zero patients by end of September 2024. The performance for 52 week waits continues to improve. As at 21 May 2024, the total waiting list was 108,391 patients. The focus had moved from validation of the waiting list to ensuring the Trust received the right referrals.

With respect to diagnostic services, at the end of April 2024 there were 6,477 patients waiting over 6 weeks for a diagnostic test of which 2,394 were over 13 weeks. Performance against the 6-week standard was 75.2%. The overall size of the waiting list had increased to 26,073. The main increase was in respect of Magnetic Resonance Imaging (MRI) as there had been reduced capacity with the loss of the Loughborough mobile and machine down time in March 2024. There was planned downtime for the CT scammer for 5-6 weeks which would impact on performance.

A deep dive into Endoscopy noted that the Trust was undertaking significantly more diagnostic tests than in 2019. This was down to addressing the backlog in demand, supporting Route to Treatment long waits and cancer performance.

There were opportunities to increase productivity by improving the systems for booking appointments, increasing the use of the facility in Market Harborough and reviewing the clinical criteria to increase the proportion of patients seen in the community.

The Committee received the LLR System Operational Plan.

4.5 Briefing for Urgent and Emergency Care *(mitigating BAF Risk 2)*

The Committee was briefed on developments in urgent and emergency care. Emergency Department attendances in April were lower than those for March 2024 although significantly higher than April 2023. Performance for the 4-hour wait standard was on track and there had been a significant improvement for the 12-hour wait standard.

The Committee noted the work to improve flow out of the hospital noting the improvements in the number of patients discharged, percentage of incomplete discharges, discharges of patients medically optimised for discharge, the timing of discharges, and length of stay. There remained challenges around pathways 1 and 2 (patients requiring support on discharge). It was noted that pathway 1 and 2 plans for the winter ahead were not yet considered sufficient and the Trust was pressing for further System support with this.

Work to support criteria-led discharge was noted. The policy had been refreshed and pathways in place for elective Orthopaedic, Urology and Surgery patients. The practice would be rolled out across the Trust and supported by changes to Electronic Patient Record. The work had been commended by NHSE which was directing other trusts to learn from UHL.

The Missed Opportunities Audit had identified three recommendations. The first, an Urgent Treatment Centre in the city was being progressed. The capital bid was under consideration by the national team; local sites were being reviewed and pathways being developed. The second related to behaviours and ensuring the Internal Professional Standards were adhered to; work was in progress to ensure the protocol was embedded. The third recommendation was to ensure that all same day emergency care and acute assessment services were brought onto one site. There was no plan to enact this recommendation although progress had been made in developing the current services at Leicester Royal Infirmary and Glenfield Hospital.

4.6 Getting It Right First Time (GIRFT) – Frailty (mitigating BAF Risk 2)

GIRFT and British Geriatric Society issued joint guidance on the management of frail patients in an acute hospital. This was used to assess how the Trust was managing frailty. The Trust provided good care for frail patients, prevented admissions that did not benefit patients, reduced readmissions and improved clinical outcomes. However, best practice was patchy. It was therefore proposed to appoint a senior Frailty Lead and a develop a Frailty Strategy to complement the clinical strategy.

There were specific recommendations in relation to assessing frailty, prevention complications, Home First, surgical liaison, rehabilitation, and primary and community care. In addition, it was recommended that a business case for a Frailty Same Day Emergency Care unit and increased support by the Frailty Emergency Squad into Emergency Department be supported and for frailty virtual wards to be expanded.

The Committee supported the recommendations, in principle, whilst acknowledging that there were significant financial implications and given the number of recommendations a need for a long-term plan. It was agreed to work with the Integrated Care Board.

5. Information items

The Integrated Performance Report M1 2024/25 was noted.

6. BAF Report

The Committee reviewed strategic risk 2 on the BAF which related to ‘failure to meet national standards for timely urgent and elective care’ which was aligned to the Committee and its work plan. OPC noted the updates to controls and key next steps and confirmed that the current risk score should remain 20 (Likelihood: Almost certain (5) x Impact: Major (4)).