Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE OPERATIONS AND PERFORMANCE COMMITTEE (OPC) MEETING HELD ON WEDNESDAY 24 SEPTEMBER 2024 ON MS TEAMS

Present:
Prof A Garcea - OPC Chair, Non-Executive Director
Dr A Haynes MBE - Non- Executive Director
Mr J Melbourne - Chief Operating Officer

Non-Voting Members
Mr L Bond - Chief Financial Officer
Ms S Favier - Deputy Chief Operating Officer
Ms H Hendley - LLR Director of Planned Care
Ms S Nancarrow - Associate Director of Operations – Cancer

In Attendance:
Ms Sue Bendelow - Assoc Director of Operations
Mr G Hall – Chief Pharmacist Information Officer
Mr R Manton – Head of Risk Assurance
Ms A Moss - Corporate and Committee Services Officer
Mr L Walker – Clinical Director, Emergency and Specialist Medicine (Deputy Medical Director elect)

RESOLVED ITEMS

102/24 WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr A Furlong, Medical Director, Ms Sarah Taylor, Deputy Chief Operating Officer and Ms J Frake-Harris, System Director UEC.

103/24 CONFIRMATION OF QUORACY

The meeting was quorate.

104/24 DECLARATION OF INTERESTS

There were no declarations.

105/24 MINUTES

Resolved – that the Minutes of the meeting of Operations and Performance Committee held on 28 August 2024 (paper A refers) be confirmed as a correct record.

106/24 MATTERS ARISING

The Action Log was received.

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

107/24 KEY ISSUES FOR ASSURANCE

107/24/1 Electronic Prescription Service

The Chief Pharmacy Information Officer briefed the Committee on the project to enable the Trust to send prescriptions electronically to community pharmacies (Paper C refers).

The need for this facility became increasingly apparent during the pandemic, particularly with the rise of virtual outpatient appointments, as patients still had to physically visit the hospital to collect their medications. The Trust and Nervecentre had planned to deliver the functionality as part of its EPR development partnership. Funding from NHSE expedited the development.

The project would enable patients to choose where to collect their prescriptions and facilitate a faster turnaround, improve prescription recording and promote UHL as the first acute hospital to go-live. The facility already existed in primary care.

The testing of the system by NHSE should be completed at the end of November 2024 and followed by local testing. It was intended the East Midlands Planned Care Centre would act as an exemplar prior to further roll-out when the Patient Administration System was replaced.

The Chief Operating Officer asked about the delays at times in getting prescriptions signed off on the wards. The Chief Pharmacy Information Officer noted that they were aware of and monitoring the issue. Actions had been identified to speed up the process including increasing the capacity of prescribing pharmacists.

It was noted that the ability of patients to collect prescriptions from community pharmacists could impact on the activity and income for the out-patient pharmacy on the hospital sites (TrustMed). The Chief Financial Officer agreed to review this. **CFO**

The Chief Pharmacy Information Officer noted that the system would improve the monitoring of prescribing practice. The System would adopt agreed formularies. Some drugs would be too expensive for community pharmacists to provide and there was the facility to block certain lines.

The Committee welcomed the initiative and asked for a further report in March 2025. **CPIO**

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

(B) the Chief Financial Officer review the impact on activity and income for TrustMed, and

(C) a further report be made in March 2025.

107/24/2 <u>Cancer Operational Performance Report</u>

The Associate Director, Cancer, provided detail on the Trust's cancer performance (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 Trust had delivered the 28-day Faster Diagnosis Standard for the eleventh consecutive month in July 2024. Performance for the 31-day wait standard was significantly challenged with radiotherapy driving the variance. The target for the number of patients waiting longer than 62 and 104 days for treatment was behind plan. At the end of August 2024, there were 410 patients waiting over 62 days, 71 patients behind plan. There were 129 patients waiting over 104 days, 19 behind plan. The backlogs were similar to those of other trusts in the region. The Associate Director reported on the actions taken and planned to improve performance and support services.

It was noted that Radiotherapy waits remained a concern for breast and prostate patients. Patients were risk stratified. The waiting list continued to grow, despite mitigations being in place. Additional mutual aid was needed until the fifth linear accelerator (Linac) was commissioned at the end of the financial year.

The Associate Director reported on a review of Urology and the three main tumour sites (Prostate, Bladder, Kidney). The outcome was appended to the report.

The Chief Operating Officer considered it would be useful to set out in future reports, for the most challenged specialities, where the Trust needed help from: UHL, United Hospitals of Northamptonshire and/or NHSE. **AD (Cancer)**

Dr A Haynes, Non-Executive Director, asked about what patients were told about waiting times for breast and prostrate cancer. The Associate Director noted that patients were told about the waiting times and that those who waited the longest were on hormone treatment. The greatest concern was for breast cancer patients as the evidence suggested that hormone treatment did not mitigate the risks in the same way as it did for prostrate cancer. Some patients were offered treatment in Northampton but chose to wait. Mutual aid had been offered from Royal Stoke University Hospital. There was a good community network for support. Whilst patients were contacted and supported, this did not reduce the wait or significantly lessen the anxiety patients experienced.

The Chief Financial Officer asked if there was a particular tumour site which impacted on performance disproportionately and how well the surgical robot was used. The Associate Director noted that breast cancer had a high volume of cases and UHL was an outlier; lower gastrointestinal and prostate cancers were challenged, and she was reviewing pathways at other hospitals which fared better. There were specific challenges around skin cancer and capacity for 'plastics'. She agreed to report back on the utilisation of the surgical robot. **AD (Cancer)**

The report noted that East Midlands Cancer Alliance (EMCA) had provided an additional £1.5m funding in 2024/25 and the list of schemes to be funded were set out in Appendix 1. The Chief Financial Officer asked whether the posts identified for some schemes were temporary or permanent. The Associate Director noted that previously a business case had been approved on the basis that the staffing costs c£1.3m (for substantive staff) would be the first call on future funding from EMCA in 2025/26. The Chief Financial Officer noted the need to be aware of the risks of non-recurrent funding streams such as EMCA and to carefully consider decisions around its utilisation.

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

(B) the next report reflects, for the most challenged specialties, from where the Trust needed more help (UHL, UHN and/or NHSE) and use of the surgical robot. **AD (Cancer)**

107/24/3 <u>Elective Care (RTT and DM01)</u>

The Deputy Chief Operating Officer provided an update on the recovery of elective care, highlighting areas of risk and noting actions (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 report addressed the progress made in reducing the waiting list and in particular treating those who had waited the longest. At the end of August 2024, three people had waited over 78 weeks for treatment. These cases were complex. There were 161 patients who had waited over 65 weeks and the majority of these patients were for Ear, Nose, and Throat (ENT) care. There was a consultant in Paediatric ENT who was on sick leave, and she was the only consultant who could perform surgery for certain cases. The performance for those waiting more than 52 weeks was better than plan at 1,964 and it was expected the position would improve.

The Trust had been asked to provide mutual aid as its position on reducing the backlog fared well against other trusts. However, there were concerns about the growing demand, potential cancellations over winter, and the impact on productivity when the Patient Administration System was deployed. The opening of the East Midlands Planned Care Centre (EMPCC) would alleviate the position.

With respect to Children and Young People the majority of delays were for ENT. The issue was the lack of paediatric beds rather than theatre capacity which meant low utilisation of the paediatric theatre list. Mutual aid was being discussed with University Hospitals of Northamptonshire. There were discussions with NHSE about ENT as there was a national shortage of consultants.

The total waiting list was continuing to rise and there had been an initial meeting to review the reasons. Whilst some actions had been identified the review raised further questions and there was more to do to understand the underlying reasons for the demand.

Dr A Haynes, Non- Executive Director, noting that day case rates had remained static, asked what could be done to improve the conversion rate. The Deputy Chief Operating Officer noted that Trust was seeking to increase the number patients treated as a day case. And the overall number was the priority rather than the conversion rate. The number of mastectomy cases done as day cases had increased. There is an audit to understand why patients planned for day cases had remained overnight, noting that some of the reasons were site-specific. For the Leicester Royal Infirmary there was no surgical day case unit, so patients went onto an inpatient ward and were likely to stay longer. At Leicester General Hospital the patients would go to Ward 31 because of the lack of medical cover and were likely to stay longer. The day case rates had reached 80% which was the target but there was an ambition to achieve 85% as the Trust was not benchmarking particularly well on day cases. There was a need to ensure patients did not stay too long at the EMPCC as there was a 23-hour ward in the Centre. There were a number of actions being taken and a need to address the nursing culture to foster confidence in staff to send patients home.

The Chief Financial Officer noting that of the 177 patients having waited over 65 weeks, 61 were on a non-admitted pathway and asked about the conversion rate. If it was high, there would be a risk to achieving the target. The Deputy Chief Operating Officer noted that the conversion rate varied according to speciality and acknowledged the risk.

The Chief Financial Officer asked about the ENT consultant who was on sick leave and whether patients could be sent elsewhere. The Deputy Chief Operating Officer noted that other centres had capacity issues and many parents had built a relationship with the clinician and were unwilling to be transferred elsewhere. It was hoped that the consultant would return shortly. For the longer term the Clinical Management Group was looking to upskill other clinicians to ensure greater resilience.

The Chief Financial Officer asked whether there was a speciality which was particularly challenged. The Deputy Chief Operating Officer referenced ENT (both adults and paediatrics) which was true for all the trusts in the region, general surgery (particularly for colorectal and complex cases) and maxillofacial surgery.

The LLR Director of Planned Care reported on diagnostic services. At the end of August 2024, 5,415 patients had waited over six weeks for a diagnostic test, of which 1,924 had waited over 13 weeks. The performance was a deterioration. The overall waiting list had increased to 24,093. The number of referrals had dropped but it was queried if this related to collective action undertaken by General Practitioners.

The actions to improve performance were noted including the work with the consultancy firm BAIN, to look at productivity and particularly for the mobile facilities.

The Chief Operating Officer highlighted the planned opening of the Community Diagnostic Centre. The Chief Financial Officer asked about the projected activity and income. The LLR Director for Planned Care agreed to provide the data. The Centre was due to open on 13 January 2025. A further report would be made to the next meeting. **LLR Dir**

The LLR Director of Planned Care reported on the LLR Planned Care Partnership. It had been agreed to rebadged activity undertaken by the Alliance as ‘UHL in the Community’. The activity would be managed by the Clinical Management Group for Clinical Screening and Imaging. There was an ambition to make greater use of the community facilities and use them for more day case surgery. It was noted that there were discussions around the Elective Recovery Fund (ERF) to ensure transparency across the System on planned and actual spend. The forecast was achievement of 120% of ERF income when the target set by NHSE was 104%.

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

(B) a further report be made on the Community Diagnostic Centre. **LLR Dir**

107/24/4 Urgent and Emergency Care
Winter Plan

The Committee was briefed on developments in Urgent and Emergency Care (UEC) (paper F 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 Associate Director reported that attendances at Emergency Department continued to rise. Whilst this was being experienced by other trusts in the Midlands the increase was higher for UHL. Performance for the standard for 4-hour waits in the Emergency Department had improved slightly. Performance for those who had been admitted was significantly lower for non-admitted. The 12-hour performance for August 2024 was 90.22%; specific pressures were caused by the wait for side rooms and mental health patients. The Trust was working with System partners to see what further support could be provided for this cohort.

The times for ambulance handovers had improved in August 2024 but the Trust was still one of the most challenged performers in the Midlands – albeit with a number of Trusts will similar performance. No patient had waited over 8 hours on an ambulance in August 2024.

The Chief Operating Officer observed that the performance for ambulance handovers was not where the Trust wanted to be but noted the increased demand and improved performance achieved over the preceding two years.

Hospital admissions had increased. NHSE had written to the Trust setting out actions to support the increased demand over the winter, all of which were in train and included Same Day Emergency Care and the use if virtual wards.

The Associate Director highlighted a risk with respect to flow out of the hospital and the performance of the transport provider. There had been an increase in referrals and quality metrics were being reviewed to ensure the patients were discharged to the right place. An audit had identified a gap of 91 beds/placements for patients of pathway 2 and the System was undertaking an options appraisal.

The Clinical Director for Emergency and Specialist Medicine noted that the Operational Plan had assumed no growth in emergency attendances which proved not to be the case.

Dr A Haynes, Non-Executive Director, asked about the decrease in attendance at the Clinical Decisions Unit and whether patients had been redirected. The Clinical Director considered the reasons were multi-factorial; there had been a seasonal change; the Respiratory Support Unit had opened; and there was greater in-reach into the Emergency Department which mitigated the need to transfer patients to the Unit.

Prof A Garcea, Associate Non-Executive Director Chair, asked whether there was a correlation between the increase in the admission rate and the increase in the number of same day discharge, or did this relate to the increased attendance at the Emergency Department. The Clinical Director was unsure. One theory suggested that it was a consequence of the reduction in primary and preventative care during the pandemic, leading to more serious presentations to secondary care. The Chief Operating Officer advised that the Integrated Care Board would suggest that was due to the local population growth.

The Associate Director presented a summary of UHL's Winter Plan. The key actions were noted as: development of Same Day Emergency Services and redirection and streaming to Urgent Treatment Centres; development of the Clinical Bed Bureau to provide a single point of contact; development of Pathway 1/Pathway 2 capacity; opening of additional winter capacity in community hospitals; opening of winter surge capacity for urgent care; and improving productivity.

It was reported that the bed gap remained unmitigated. The Chief Operating Officer noted that the System's Winter Plan had yet to be finalised and needed to be more robust. He considered that the Trust had done everything it could within the current financial constraints.

The Chief Financial Officer asked where the additional 36 beds referred to, would be located. The Associate Director agreed to send him the detail noting that they would be in different wards and some areas had been refurbished to facilitated rapid boarding. **AD**

Dr A Haynes, Non-Executive Director, reflecting the flawed assumption about growth, noted that January and February 2025 would be particularly challenging. He asked about progress with respect to the 'flu vaccination programme, and support for frail patients. It was agreed to ask about the vaccination programme for staff at the People and Culture Committee meeting the following day. Prof A Garcea, Associate Non-Executive Director Chair, understood the vaccination programme in primary care had commenced and stratified patients according to risk. In response to a question, she considered that the programme would not be affected by the planned collective action on the part of General Practitioners. **AH NED**

With respect to frailty the Clinical Director reported that an Associate Medical Director would be appointed to lead on frailty and a Same day Emergency Care unit for frailty would be established in the next three months. In addition, there was process for Pre-Transfer Clinical Discussion And Assessment (PTCDA) for care homes.

Dr A Haynes, Non-Executive Director, highlighted the need to ensure additional provision for out of hospital care. He asked the Chief Operating Officer how confident he was about the winter plan. He reflected that the governance had improved but that it was for the System, and not just UHL, to drive the actions.

Prof A Garcea, Associate Non-Executive Director Chair, asked whether actions in the plan, specifically Same Day Emergency Care and the single point of access to the bed bureau could be expedited. It was not known whether this was possible, and progress would be reported monthly to the Committee.

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

(B) that the location of the additional beds be provided to the Chief Financial Officer **AD**

(C) that assurance be sought with respect to the staff 'flu vaccination programme. **AH NED**

108/24 ITEMS FOR NOTING

108/24/1 Integrated Performance Report M5 2024/25

Resolved – that the report be received and noted.

109/24 CONSIDERATION OF BAF RISKS IN THE REMIT OF OPERATIONS AND PERFORMANCE COMMITTEE

109/24/1 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 risk pertaining to the patient transport provider had been captured. The Committee agreed that the risk score should remain at 20.

Resolved – that the report be received and noted.

110/24 ANY OTHER BUSINESS

There was no other business.

111/24 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.

112/24 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

There were no issues to be escalated, noting that the Winter Plan would be presented to The Trust Board.

113/24 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the OPC be held on Wednesday 30 October 2024 from 10.00 am (virtual meeting via MS Teams).

The meeting closed at 11.42am

Alison Moss - Corporate and Committee Services Officer

Cumulative Record of Members' Attendance 2024/25

Voting Members

Name	*Possible*	*Actual*	*% attendance*
Prof A Garcea *(Chair from September 2024)*	5	4	80
J Worrall (Chair) *(until September 2024)*	5	5	100
A Haynes	6	6	100
B Patel *(until end June 2024)*	3	0	0
J Melbourne	6	5	83
A Furlong/ J Hogg	6	5	83

Non-voting Members

Name	*Possible*	*Actual*	*% attendance*
R Mitchell	6	0	0
J MacDonald *(until June 2024)*	3	0	0
A Moore *(from July 2024)*	3	0	0
L Bond *(from August 2024)*	1	1	100
M Brearley *(from June 2024)*	2	1	50
L Hooper *(until June 2024)*	3	0	0
H Hendley	6	4	66
S Favier	6	5	83
S Taylor	6	5	83
S Nancarrow	6	6	100
R Briggs	6	0	0
J Frake-Harris *(from July 2024)*	3	2	66