Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE OPERATIONS AND PERFORMANCE COMMITTEE (OPC) MEETING HELD ON WEDNESDAY 28 SEPTEMBER 2022 AT 10.00AM, VIRTUAL MEETING VIA MICROSOFT TEAMS

Present:
Mr M Williams - OPC Chair, Non-Executive Director
Dr A Haynes - Non-Executive Director
Mr B Patel - Non-Executive Director

In Attendance:
Dr R Abeyratne - Director of Health Equality and Inclusion
Mr M Archer - Interim Associate Director of Operations – Cancer
Mr D Barnes - Deputy Medical Director (non-voting)
Mr S Barton - Deputy Chief Executive (for 83/22/1)
Mr R Binks - Deputy Chief Nurse (non-voting)
Ms S Favier - Deputy Chief Operating Officer
Ms H Hendley - LLR Director of Planned Care (ex officio)
Mr J Jameson - Deputy Medical Director
Mr J McDonald - Trust Board Chair (ex officio)
Mr R Manton - Head of Risk Assurance
Mr J Melbourne - Chief Operating Officer (non-voting)
Mr R Mitchell - Chief Executive (non-voting)
Ms A Moss - Corporate and Committee Services Officer
Ms S Taylor - Deputy Chief Operating Officer
Mr J Worrall - Associate Non-Executive Director (non-voting)

RESOLVED ITEMS

79/22 WELCOME AND APOLOGIES

Apologies for absence were received from Ms G Collins-Punter, Associate Non-Executive Director, Mr A Furlong, Medical Director and Ms J Hogg, Chief Nurse.

80/22 DECLARATIONS OF INTERESTS

Resolved – that it be noted that no declarations of interest were made at this meeting of the Operations and Performance Committee.

81/22 MINUTES

Resolved – that the Minutes of the meeting of Operations and Performance Committee held on 24 August 2022 (paper A refers) be confirmed as a correct record.

82/22 MATTERS ARISING

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

83/22 KEY ISSUES FOR ASSURANCE

83/22/1 Reconfiguration Post Project Assessment

The Committee received a report on the risks associated with the interim reconfiguration programme (paper C). The interim reconfiguration relocated Level 3 ICU and associated services from the Leicester General Hospital site. The report identified the risks which were resolved, the risks which remained and new risks identified during and following completion of the project. There were 10 risks outstanding from the original risk register which would now be managed locally on the Clinical Management Group risk registers. There were six new risks identified following the interim

reconfiguration.

Ms S Taylor, Deputy Chief Operating Officer, reflected on the instigation of the project in 2015. The original assumptions had been revisited primarily because of the shift in emergency activity. Additional capacity at Glenfield Hospital had been created to facilitate the moves but, in the event, this capacity had been absorbed necessitating a complex sequence of service moves to achieve the relocation of ICU services.

The report set out the key changes in the bed base across the three sites for the affected Clinical Management Groups. Mr J Worrall, Associate Non-Executive Director, noted the loss of medical beds at the Leicester Royal Infirmary site. Whilst this had been offset by beds at Leicester General Hospital, he considered medicine's capacity was stretched and the reduced number in close proximity to the Emergency Department would impact on ambulance handovers. The Deputy Chief Executive referenced the number of patients who were medically fit for discharge and that beds would be available if this cohort were supported in the community or their own homes. The Chief Operating Officer agreed and thought the focus should be on patient flow in medicine to ensure the efficient use of the beds, noting that the interim reconfiguration had improved the surgical flow. The Chief Operating Officer agreed that there had been a real challenge with medical flow as a result of the move and this was a risk following reconfiguration.

Dr A Haynes, Non-Executive Director, asked whether there were issues with medical outliers at Leicester General Hospital, whether the return rate was acceptable and how the risk was being managed.

The discussion concluded that it was too early to tell what the impact of the relocation had been on ambulance handovers and elective capacity. The Committee requested a further report in 6 months' time. The Chief Executive noted that the long-term strategy should be to reduce the reliance on acute beds. **DCOO**

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

(B) a further report be made in six months. **DCOO**

83/22/2 <u>UHL Urgent and Emergency Care and Winter Plan Update</u>

The Committee received a report regarding actions taken to improve patient flow for patients on urgent and emergency care pathways (paper D). A report on the Winter 2022/23 Plan (Paper D1) was presented.

Ms S Taylor, Deputy Chief Operating Officer, highlighted the key achievements for the last two months, which included the opening of the Ashton Care Home; opening a reablement ward; enhanced rapid flow procedure; and extended opening hours at the Minor Illness and Minor Injury Unit and the cardio-respiratory service. Appended to the report was the Emergency Care Scorecard and Urgent and Emergency Care action plan to provide assurance regarding the entirety of actions undertaken; targets; and performance.

The Chief Operating Officer noted the improved performance in the last two months but reported there had been a deterioration in the last two weeks. During the preceding weekend there had been 152 more admissions than discharges and at one point 96 patients were awaiting admission in the Emergency Department. It had not been possible to divert any ambulances as neighboring hospitals were also experiencing considerable pressures.

Dr A Haynes, Non-Executive Director, asked about the Same Day Emergency Care (SDEC) activity and what the aspiration was to increase capacity. The Chief Operating Officer reported that the model was changing and moving towards that promoted in the Ian Sturgess Review. The targets were under discussion, but it was proving difficult to identifying meaningful metrics.

Mr M Williams, OPC Chair, Non-Executive Director, observed that the emergency score card set a target number for patients waiting for a bed at 8am as 20 patients. Whereas, in the report to Finance and Investment Committee on ambulance handover schemes, that target had been 40

patients. The Chief Operating Officer clarified that the target of 20 patients was where the Trust wanted to get to. However, at this stage, with the implementation of pre-transfer unit scheme specifically the plan was aimed to see progress, down from an average of 50-56 patients, to 40 patients.

Mr J Worrall, Associate Non-Executive Director, asked what more the Trust could do to influence that which was within its control, for example, in relation to the discharge hub.

The Trust Board Chair noted that the 'TTO issue', that is the ability to fulfil prescriptions for patients being discharged, was often raised in discussion with system partners. The Chief Executive noted that he was convening weekly meetings with lead officers to address the delays relating to TTOs. The Chief Operating Officer observed that the Pharmacy Department was running at a significant vacancy rate. He added that whilst the issues needed to be addressed and was in the control of the Trust, the delays only affected a handful of patients and the impact of this should not be overstated.

The Trust Board Chair wondered if the Trust needed to be clearer about its expectations of system partners. The Chief Executive reported that the Trust was working well with system colleagues to gain a clearer understanding and agreement on the key issues. Referring to the Emergency Care Scorecard he considered that it was important to focus on the ambulance handovers at 30-minutes and 60 minutes and to identify the actions that would make the biggest difference,

The Trust Board Chair noted the recent successes but was disappointed that performance had deteriorated in the last two weeks. He asked whether there was appropriate escalation. The Chief Operating Officer reported that the Trust had been at Operational Pressures Escalation Level (OPEL) 4 for over a year, and that was unusual. As such many 'escalations' remained in place continually.

The Chief Operating Officer presented the Winter Plan for 2022/23 which set out 20 key interventions and how success would be measured. There had been an exercise to anticipate how many beds would be needed to cope with winter pressures. The best-case scenario was a bed gap of 132 and the worst case 348. National advice was to assume the 348 gap. The Committee considered that creating additional capacity and improved performance of the Urgent Treatment Centres was key. There would be further discussion at the Trust Board the following week.

Mr B Patel, Non-Executive Director, asked with respect to initiative W16 'Right size UTC walk in capacity', whether it was known what performance was specified in the contracts.

The Committee discussed how the system was responding to the challenge. The Chief Executive noted that the Trust was working in collaboration with system partners but that it was inevitable, given that the risks sat with East Midlands Ambulance Services and UHL that the Trust was taking on the leadership role. He noted that the Trust had been proactive in ensuring community provision through the arrangement with Ashton Care Home and that it might need to take similar actions in the near future.

The Chief Operating Officer highlighted that the winter plan was ambitious and broad ranging, yet more needed to be done given the scale of the challenge for winter 2022/23.

Resolved – that the contents of the report be received and noted.

83/22/3 Cancer Quality and Performance Report

The Committee received a report on cancer performance for the latest published dataset (July 2022), a performance overview for August and prospectively for September 2022 (paper E).

The Associate Director of Operations (Cancer) reported there had been improvements in eight of the ten nationally reported standards. However, cancer services remained very challenged. Key areas of concern were the high numbers of patients waiting more than 62 and 104 days, notably within Urology. There were constraints in capacity and referral and conversion rates had increased

since the pandemic placing additional demands on oncology and radiotherapy services. UHL was an outlier for the number of patients in the backlog still waiting a decision to treat.

It was reported that performance in 31- and 62-day standards would deteriorate as the Trust focused on treating the longest waiting patients who had already breached.

The Associate Director of Operations (Cancer) reported that a review of demand and capacity for each tumour site had commenced. The Trust was working with regional colleagues at NHSEI to explore mutual aid.

The Trust Board Chair reflected on the variations in performance, for example, in skin cancer and asked what lessons could be learnt and given the variability whether this had been predicted. The Associate Director of Operations (Cancer) agreed that greater focus could be given to anticipating issues and looking ahead.

Dr A Haynes, Non-Executive Director, asked about the conversion rate and its impact on the backlog. It was noted that time would tell if they were to become the new normal or were reflective of the disruption caused by the pandemic. The Chief Operating Officer noted that support had been requested to review the conversion rate ads the Trust was an outlier.

The Committee noted the action, previously agreed, to undertake deep dives by tumour site at its meetings. It was agreed that urology and colorectal cancer would be the priority sites.

Resolved – that the contents of the report be received and noted.

83/22/4 Elective Care (RTT and DM01)

The Committee received a report on the progress to recover elective care, highlighting areas of risk and summarising actions (paper F).

The Director of Planned Care reported on the Elective Recovery Fund schemes noting that whilst there was an underspend, the forecast was to spend the allocated £39.9m. There was a need to increase the levels of activity, currently around 80-90%, to ensure the condition for funding could be met. There was a need to ensure value for money, particularly for the Vanguard service at Glenfield Hospital, and to ensure that activity outside of the Trust was captured appropriately.

It was noted that work on the Elective Care Hub was progressing well. The Short-Form Business Case had been approved and confirmation regarding the enabling works was expected at the end of the week. Approval would be sought from Finance and Investment Committee and the Trust Board for the Outline Business Case. The risk for the Trust was the uncertainty regarding funding for activity in future years.

Ms S Favier, Deputy Chief Operating Officer, provided an update on the cohort of patients waiting over 104 weeks for treatment. There had been 265 patients at the end of August 2022. This exceeded the trajectory of 239. A large proportion were complex cases whose treatment would be resource intensive. However, given the profile of the overall waiting list, it was predicted that the number of patients, having waited over two years, would increase to 457 by the end of October 2022. The majority of patients were waiting for general surgery.

The Chief Operating Officer, acknowledging the national spotlight on the number of patients having waited over 104 weeks, noted that it was the tip of the iceberg compared to the total waiting list and the high numbers having waited over 52 and 78 weeks. The Committee noted that the overall waiting list had grown to over 120,000 patients.

The Chief Operating Officer highlighted the difficulty in balancing the competing priorities in reducing the elective backlog, responding to increased demand for cancer services and meeting emergency care demand.

The Committee asked about the process for validation of the waiting list which was explained.

Ms S Favier, Deputy Chief Operating Officer, reported that Edge Health had been commissioned to undertake demand and capacity modelling for each speciality. It was noted that improvements to processes, and the Elective Hub would create additional capacity. However, discussions were being had with NHSE/I at a regional level regarding mutual aid as it would not be possible to achieve sufficient capacity at the Trust.

The Chief Executive highlighted the inequity for patients in LLR who had long waits when over the border, patients in neighbouring counties did not. He considered there was a need for a pooled waiting list and to explore new ways of working with local trusts.

Resolved – that the contents of the report be received and noted.

84/22 ITEMS FOR NOTING

84/22/1 Integrated Performance Report M5 2022/23

Resolved – that the contents of the Integrated Performance Report M5 2022/23 (paper G refers) be received and noted.

85/22 CONSIDERATION OF BAF RISKS IN THE REMIT OF OPERTATIONS AND PERFORMANCE COMMITTEE

85/22/1 Board Assurance Framework

The Committee reflected on the reports received and discussions in relation to the risks assigned to the Committee. It was noted that work on the winter plan, urgent and emergency care action plan and the eight elective recovery interventions would provide some mitigation. However, the risk remained that demand could overwhelm capacity.

Resolved – that the contents of the report be received and noted.

86//22 ANY OTHER BUSINESS

There were no items of any other business.

87/22 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 the OPC.

88/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be highlighted to the 6 October 2022 public Trust Board via the summary of this Committee meeting, for information:

- Urgent and Emergency Care and Winter Plan Update – the need to be clear with the system about expectations and the need to act decisively.
- Elective Care (RTT and DM01) – performance for 104 week waits and overall patient waiting list.

89/22 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the OPC be held on Wednesday 26 October 2022 at 10.00am (virtual meeting via MS Teams).

The meeting closed at 11.44 am

Alison Moss - Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2022-23 to date):
Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
M Williams (Chair)	6	6	100	J Melbourne	6	5	83
A Furlong	6	4	66	E Meldrum (until May 2022)	1	0	0
A Haynes	6	5	83	R Mitchell	6	6	100
J Hogg (from May 2022)	5	3	66	B Patel	6	6	100
J McDonald	6	5	83				

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
G Collins-Punter	6	3	50	J Worrall	6	6	100
H Hendley	6	5	83				