UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE OPERATIONS AND PERFORMANCE COMMITTEE (OPC) MEETING HELD ON WEDNESDAY 24 AUGUST 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
Ms S Favier - Deputy Chief Operating Officer
Mr A Furlong - Medical Director (non-voting)
Ms H Hendley - LLR Director of Planned Care
Ms J Hogg - Chief Nurse (non-voting)
Mr R Mitchell - Chief Executive (non-voting)
Ms A Moss - Corporate and Committee Services Officer
Ms S Nancarrow - Associate Director of Operations – Cancer
Ms S Taylor - Deputy Chief Operating Officer
Mr A Williams - Chief Executive, LLR ICB
Mr J Worrall - Associate Non-Executive Director (non-voting)

RESOLVED ITEMS

69/22 WELCOME AND APOLOGIES

The Chair welcomed Mr A Williams, Chief Executive, LLR Integrated Care Board, to the meeting for the discussion on urgent and emergency care. Apologies for absence were received from Mr J Melbourne, Chief Operating Officer, Mr J McDonald, Trust Board Chair and Ms G Collins-Punter - Associate Non-Executive Director (non-voting)

70/22 DECLARATIONS OF INTERESTS

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

71/22 MINUTES

It was noted that Mr B Patel, Non-Executive Director, had under Minute 63/22/1 requested data on the usage of the Urgent Treatment Centres, what the contract stipulated in terms of capacity/performance.

Resolved – that the Minutes, as amended, of the meeting of Operations and Performance Committee held on 27 July 2022 (paper A refers) be confirmed as a correct record.

72/22 MATTERS ARISING

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

73/22 KEY ISSUES FOR ASSURANCE

73/22/1 LLR System Plan for UEC

The Committee welcomed Mr A Williams, Chief Executive, ICB, to the meeting, to present a paper on system flow and the priorities for operational resilience and sustainable transformation (paper .

Mr A Williams considered that the LLR system was in a better place than others, as there was good

partnership working and engagement. He acknowledged the huge amount of work undertaken over the years to improve system flow, although with variable degrees of success. He considered that with respect to flow dynamics the system was doing well in managing patient demand, with lower users of ambulances and conveyances.

Mr A Williams reported that the LLR system had the second highest number of available appointments in primary care, per 1,000 population. Almost 70% of these were now face to face appointments. He acknowledged that the statistics did not chime with the perceptions of the public and there was work to be done on patient engagement.

It was note that the capacity metrics were broadly comparable with other trusts.

Mr A Williams noted that the data did not provide an explanatory correlation to the increased delays in ambulance handovers, which had been markedly worse over the last few months. He described this as a conundrum worthy of further exploration. He considered that, whilst it was important to progress initiatives to improve flow, there was a need to engage with clinical leaders to understand how clinical behaviours were impacting. He added that it should not be seen as a criticism of clinicians but a desire to understand how leadership, morale, etc. impacted on decision-making.

Mr M Williams, Non-Executive Director, OPC Chair, asked whether the problem with delayed ambulance handovers simply related to demand. Mr A Williams, noted that figures for ambulance conveyances had remained relatively stable, but noted that the acuity of patients had increased post pandemic. In addition, there had been increased footfall at the Emergency Department of patients who could have been seen elsewhere. He wondered whether the Urgent Treatment Centres should be recommissioned and for a different type of Centre to be located in the city away from the Leicester Royal Infirmary.

Mr J Worrall, Associate Non-Executive Director, observed that the Trust was one of the six worst in the country for ambulance handovers and that this was the case prior to the pandemic and therefore a long-standing issue. He agreed that how clinicians worked and the impact of their decision on flow should be explored.

Mr B Patel, Non-Executive Director, considering the impact on outflow, asked whether there was more information on capacity in social care, as it was impacting on hospital discharge. He noted the vacancy rate for GPs which he thought would only get worse in light of the national shortage. He agreed there needed to be more patient engagement for health literacy and to address negative perceptions.

Dr A Hayes, Non-Executive Director, asked whether the aggregated data masked the small number of practices that should be targeted. He thought that some were not following the right pathways, for example, the rapid access pathway and there was a need to understand how this was driving demand. He considered that there should be discharge capacity modelling to understand what capacity was needed for patients on pathways 1 and 2.

Mr A Williams noted the work underway with the 26 Primary Care Networks to create enhanced access plans and specific initiatives for the five General Practices which were struggling the most.

The Medical Director, noted the favourable metrics on ambulance conveyances and access, but noted that in relation to ambulance handovers, the System was failing. He considered that the Emergency Department worked well when there were no patients waiting for beds or medical outliers in surgical beds. There was a need for inpatient capacity. He observed that the length of stay, and acuity of patients had increased, however, so had the number of patients medically fit for discharge. This suggested the need to consider capacity for outflow and what patients on pathways 1 and 2 needed. The Medical Director considered staffing levels as fundamental. He reflected on the experience of the last weekend when the Trust had been unable to staff the Discharge Team which had impacted on flow. He questioned whether this risk had been appropriately escalated to the System.

Mr R Mitchell, Chief Executive, noted that the system needed to address emergency care and ambulance handovers as its number one priority. He acknowledged there were many actions within

the gift of the Trust to be addressed, but there needed to be a change in the operation of the Urgent Treatment Centres before winter. The priority for the coming winter would be to ensure sufficient capacity and for the following year the transformation of care and pathways.

Mr A Williams reported on the development of a winter plan and the mitigations to reduce the shortfall in beds. The plan would set out the best case, worst case, and most likely scenario. The demand metric would consider the likely increase in respiratory illness, norovirus, and the potential of reduced efficacy of vaccinations. An increase of 297 virtual beds was planned, which would equate to 100 physical beds. The bed shortfall, unmitigated, was between 200 and 290. With appropriate mitigations this would reduce to between 80 and 90 beds. There were many challenges in mitigating this shortfall, including staff in community hospitals and clinical capacity to affect discharges. In acknowledging the point made by the Medical Director regarding the Discharge Team, Mr A Williams noted that there was an existing agreement to redeploy staff across the system and that consideration should be given to how best to deploy staff to ensure patient flow. It was noted that there would be a nominated Director for the Winter Plan. **CE, ICB**

The Committee thanked Mr A Williams, who agreed to make a further report on the modelling for the Winter Plan and plans to increase capacity.

Resolved – that (A) the contents of the report be received and noted; and

CE, ICB

(B) the Chief Executive, Integrated Care Board, provide a further report on modelling for Winter 2022/23.

73/22/2 UHL Urgent and Emergency Care

The Committee received a report (paper D refers) on performance, priorities and actions relating to urgent and emergency care. Ms S Taylor, Deputy Chief Operating Officer, noted that attendance at Emergency department had significant decreased in July 2022 and there had been a slight improvement in performance. The key issue to address was ambulance handovers which stood at 34.7% for delays over 60 minutes. The actions to improve performance were outlined, including opening 24 beds in a care home in Hinckley; an additional ward at Leicester General Hospital; opening community hospital beds and extending opening hours for the Minor Illness and Minor Injury Unit.

Ms S Taylor outlined the initiative to increase the number of patients who could be treated at the GP Assessment Unit and the Same Day Emergency Centre (SDEC). The Cardiology and Respiratory SDC had secured funding to increase staffing levels which would alleviate the pressure of the Clinical Decisions Unit (CDU).

The Committee noted the report of Mr Ian Sturgess, IMP Healthcare Consultancy, had identified nine priority actions and 51 recommendations. The nine priority areas were set out in the report and action plans would be developed with robust metrics. It was noted that the different action plans would be consolidated for the Acute Care Collaborative (referencing the origin of the action). This would present a consistent picture and streamline the monitoring process. In response to a question from Mr M Williams, Non-Executive Director, OPC Chair, Ms Taylor confirmed that the plan would be presented to the next meeting of the Committee. **DCOO**

It was noted that the UHL winter planning process was in place.

Work on improving flow out of the hospital was noted including improved practice in discharging patients and provision of additional community capacity.

The reporting systems for Urgent and Emergency Care were being consolidated and an ‘Emergency scorecard’ introduced.

Mr B Patel, referencing the report of Mr Ian Sturgess, asked whether the Trust was aware of the issues and could have anticipated the recommendations. Ms S Taylor, noted that some of the actions were already in train, but the report provided a greater focus on some actions and collaboration in the System. The Medical Director noted the value of an independent and objective

assessment of the situation, using benchmarking data and good practice from other systems,

Mr M Williams, Non-Executive Director, OPC Chair, summarised the discussion and noted the need to review the action plans, integrate them into the LLR System Plan, and focus on the actions that made the biggest impact.

Resolved – that (A) the contents of the report be received and noted; and

(B) that the Action Plan for urgent and emergency care be presented to the next meeting. **DCOO**

73/22/3 Elective Care (RTT and DM01)

Ms S Favier, Deputy Chief Operating Officer presented a report (paper E refers) detailing the Trust's elective care recovery progress and the latest position for key Referral to Treatment (RTT) performance highlighting areas of risk and summarising actions.

The Committee noted the progress in reducing the waiting list. At the end of July 2022, 363 patients had been waiting over 104 weeks. This was 13 higher than planned, however there were no 'capacity breaches' (the remaining were complex cases and those exercising patient choice). It was anticipated that the number waiting more than 104 weeks would be reduced to 239 by the end of August 2022, and that the national target to achieve zero waits and capacity breaches would be achieved in October or November 2022. The Committee noted the increased focus on patients having waited over 78 and 52 weeks and requested further data for the following meeting. **DCOO**

The Committee noted the Elective Diagnostic Performance (DM01 update) which was broadly in line with expectations.

The Committee noted the system and UHL spend on schemes attributed to the Elective Recovery Fund. It had been confirmed that the underspend would not be recouped for the first six months for 2022/23. However, there was a degree of uncertainty regarding the second half of the year as the activity levels were below target. There were plans to improve performance.

With respect to the Elective Hub, the Committee noted that the Short-Form Business case had been submitted, in draft, to NHS England. It was hoped that a decision would be made in September 2022, enabling the Trust to draw down capital funds. In the meantime, the project was proceeding, noting that there was a risk, albeit a low risk, for the Trust as it was not yet able to access capital monies. The Chief Executive emphasised the positive impact the Elective Hub would have on elective care and performance.

Resolved – that (A) the contents of the report be received and noted; and

(B) to provide a further report on the overall waiting list and trajectories for 52 and 78 week waits. **DCOO**

73/22/4 Cancer Quality and Performance Report

The Committee received a report on the performance of cancer care in June 2022 a performance overview of July 2022 and prospectively for August 2022. Ms S Nancarrow, Associate Director Operations – Cancer Services, reported that cancer services remain very challenged. Performance for 31-day and 62-day standards would deteriorate as the focus was on the patients having waited the longest and already breached. The key areas of concern were the high number of patients having waited over 62 and 104 days. The Trust was now part of the Tier 1 NHS England escalation meetings. It was noted that capacity constraints across the pathways was a significant challenge and referral rates remained above pre-pandemic levels with an increase in the conversion rate. It was reported that the Trust was an outlier for the number of patients waiting for a decision to treat. A review of the demand and capacity for each tumour site had been initiated. This would be used to update action plans. A report on capacity modelling would be presented to the next meeting. **ADO**

There had been improvements in three of the ten nationally reported standards; 2-week wait breast symptomatic; 31-day subsequent drugs and 62-day standards. A Cancer Summit had been held the previous month which had highlighted the three key areas to address: demand; sustainability of workforce and funding. The actions agreed were set out in the report.

It was noted that East Midlands Cancer Alliance had approved £105k funding to target the biopsy backlog reduction in Urology. This had enabled 80 patients to receive a diagnosis and put on an appropriate pathway. An update on the oncology investment was received.

Dr R Abeyratne, Director of Health Equality and Inclusion, reported on the work to review the experience of patients at different stages of cancer in relation to health inequalities. There was a specific focus on colorectal cancer as LLR was an outlier.

The Committee asked for more information on the medium and long-term plans for recovering cancer performance and, specifically urology, at its next meeting

ADO

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

(B) a further report on the medium and long-term plans for recovering cancer performance and, specifically urology, be presented to the next meeting. **ADO**

73/22/5 Board Assurance Framework

Mr R Manton, Head of Risk Assurance, presented the second iteration of the refreshed 2022/23 Board Assurance Framework (BAF) outlining the risks pertaining to the Committee. Having defined the risks, the shift of focus would be to review the risks and assessing assurance, The Key Lines of Enquiry for the Committee to consider when receiving reports were provided.

Mr M Williams, Non-Executive Director, OPC Chair, highlighted the importance of single action plans, that were prioritised with a clear understanding of what outcomes they were intending to deliver.

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

74/22 ITEMS FOR NOTING

74/22/1 Integrated Performance Report M4 2022/23

Resolved – that the contents of the Integrated Performance Report M4 2022/23 (paper H refers) be received and noted.

74/22/2 Information on targeted support for Tier 1 Providers (letter from NHS England)

Resolved – that the letter from NHS England regarding the targeted support for Tier 1 Providers (paper I refers) be received and noted.

75/22 ANY OTHER BUSINESS

There were no items of any other business.

76/22 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.

77/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the following items be highlighted to the 1 September 2022 public Trust Board via the summary of this Committee meeting, for information:

- **LLR System Plan for UEC and Urgent and Emergency Care** (the integration of UHL's

action plans into the consolidated plan for the Acute Care Collaborative; the nomination of Director for winter; the need to understand the high number of ambulance handovers given the demand and capacity metrics which were comparable to other trusts; and the need to review the Winter Plan and bed gap)

- **Elective Care** – to note the missed target for patients waiting over 104 weeks

- **Cancer performance** – to note the limited assurance and the considerable work needed to improve performance.

78/22 DATE OF THE NEXT MEETING

Resolved – that the next meeting of the OPC be held on Wednesday 28 September 2022 at 10.00am (virtual meeting via MS Teams).

The meeting closed at 11.39 pm

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)	5	5	100	J Melbourne	5	4	80
A Furlong	5	4	80	E Meldrum (until May 2022)	1	0	0
A Haynes	5	4	80	R Mitchell	5	5	100
J Hogg (from May 2022)	4	3	75	B Patel	5	5	100
J McDonald	5	4	80				

Non-voting members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possib le*	*Actual*	*% attendance*
G Collins-Punter	5	3	60	J Worrall	5	5	100
H Hendley	5	4	80				