Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE OPERATIONS AND PERFORMANCE COMMITTEE (OPC) MEETING HELD ON WEDNESDAY 26 JANUARY 2022 AT 10.00AM, VIRTUAL MEETING VIA MICROSOFT TEAMS

Present:
Mr M Williams - OPC Chair, Non-Executive Director
Mr A Haynes - Adviser to Trust Board
Mr J McDonald -Trust Board Chair (non-voting)

In Attendance:
Mr A Furlong - Medical Director (for the latter part)
Ms E Meldrum - Acting Chief Nurse
Ms D Mitchell - Acting Chief Operating Officer
Mr R Mitchell - Chief Executive
Ms A Moss - Corporate and Committee Services Officer

As the meeting was inquorate the items were recommended rather than resolved.

RECOMMENDED ITEMS

01/22 APOLOGIES

Apologies for absence were received from Ms V Bailey, Non-Executive Director, and Mr B Patel, Non-Executive Director.

02/22 DECLARATIONS OF INTERESTS

There were no declarations of interest.

03/22 TERMS OF REFERENCE

The terms of reference for the Operations and Performance Committee were presented. It was noted that the membership would be reconfirmed.

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

04/22 KEY ISSUES FOR ASSURANCE

04/22/1 Performance Briefing: Urgent and Emergency Care

The Acting Chief Operating Officer presented paper B which provided a briefing on the performance of Urgent and Emergency Care. The Acting Chief Operating Officer wished to provide a context for the report given the pandemic, noting that on that day there were 247 inpatients with Covid-19; 4 of whom where in intensive care. Twenty-two beds had been restricted beds in line with infection prevention measures which had created additional constraints. The staff sickness rate was 11.1% with particular areas experiencing high rates. There were 220 patients medically fit for discharge/'no reason to reside' compared with an average of 149 in December 2021.

It was noted that UHL's performance (type 1 and 2) for December 2021 was 57.1% and the final performance for UHL and LLR was 69.5%. The national ranking for the month was 78Th out of 113. With respect to ambulance handovers, it was noted that 24.6% patients had waited over an hour on an ambulance. The national standards for patient care were adhered to and the weekly harm reviews had not identified any major harm. The Acting Chief Operating Officer considered patients waiting on ambulances which should be a rare occurrence.

The performance against national standards was set out in the report. It was noted that the key challenges were those patients waiting longer than 12 hours in the Emergency Department.

The performance within the Emergency Department was impacted by the flow through the hospital and the ability to discharge inpatients.

Mr A Haynes, Advisor to the Trust, asked about the patients waiting over 12 hours in the Emergency Department and the potential for patient harm. The Acting Chief Operating Officer noted that some patients were waiting up to 24 hours in the Department and these patients were usually waiting for beds and results of Covid-19 testing. The length of stay for Medicine had gone up slightly; there were 247 patients having stayed over 21 days across all specialities . The main issue relating to bed availability was the ability to discharge patients who were medically optimised for discharge. Three additional medical wards had been opened to cope with the demand. Noting the problems in relation to patient flow and delayed discharge, the Acting Chief Operating Officer observed that whilst the availability of domiciliary care and care home provision was limited, there were internal challenges for the Trust to be address, not least staff shortages.

Mr A Haynes, Adviser to the Trust, asked about the process of admitting patients from the Emergency Department to the appropriate speciality. The Acting Chief Operating Officer reflected that this had been picked up by NHSI when visiting the Emergency Department. The Medical Director had overseen the revision of clinical professional standards to ensure the process was robust. The ability to admit patients direct to a speciality was complicated by the need to move patients across different sites, arranging ambulances and Covid-19 testing. She added that there was work to be done to improve the flow from the Clinical Decisions Unit.

The Chief Executive noted the performance set out in the report and that patients waiting on ambulances, the time taken to assess and admit patients led to a poor patient experience. However, external assurance had been provided to note that the service was safe.

The Chief Executive considered that there were actions that could be taken immediately to improve care and this would include increasing the presence of senior medical personnel for bank holidays, the focus of leaders on emergency performance and providing additional clinical leadership. There was a need to start planning for next winter and for the whole system to do things differently and at scale in order to make a difference. The use of the Brandon Unit for elective care would assist. The Chief Executive considered that the Trust and LLR System needed a clear emergency care plan and to ensure greater rigour in reporting and oversight.

The Acting Chief Nurse, reflected feedback from NHSI regarding discharge processes, and that acute trusts were tending to be risk adverse when it came to assessment for discharge. It had been suggested that Allied Health Professionals and Physiotherapists could undertake more assessments in the community which would give a more realistic assessment. She thought that the Trust and Leicestershire Partnership NHS Trust could work more collaboratively with a more flexible staffing resource. There was a need for creative solutions and for a shared vision.

Mr J McDonald, Trust Board Chair, noted that attendance at the Emergency Department was 12.2% lower in December 2021 than December 2019 but the admission rates were static. The Acting Chief Operating Officer observed that there had been an increase in the number of patients walking into the Department and this was probably due to the reduced access to other services during the pandemic. Mr J McDonald, Trust Board Chair, wondered whether the trend would continue and whether general practice would continue to act as 'gatekeeper'. He considered that it was timely to review the role of primary care and create a shared vision of its role in the system. He also thought that the governance and vison for the Alliance could be strengthened and that a longer term solution would be a strong provider collaborative to give a greater focus to urgent and emergency care.

The OPC Chair summarised the discussion noting the three priorities for the Trust were:

- improved management of the emergency pathways,
- greater executive oversight and support
- early planning for Winter 2022/23.

He added that whilst it was important for the Trust to improve its performance, there was a need to develop a clear and collective plan with system partners to bring about greater change.

COO

It was agreed to request a report on improving emergency care over the next 3,6 and 12 months.

Recommended – that (A) the contents of this report be received and noted,

and (B) to request a report on improving emergency care over the next 3,6 and 12 months. **COO**

04/22/2 Quality and Performance Cancer Report

The Acting Chief Operating Officer presented paper C which reported on the performance for cancer care highlighting known risks and actions to mitigate risks and improve performance. The Acting Chief Operating Officer reported that the pandemic had impacted on performance and brought about changes to pathways, paused elective activity during earlier waves and restricted the capacity in light of social distancing requirements. It was reported that activity was stable but performance was deteriorating given the increase in referrals.

Of the cancer performance standards, the Trust had achieved one in November 2021 and was forecasting to achieve three standards in December 2021. Performance for all standards was challenged as the demand and conversion rate had increased, there was a backlog for diagnostic services and capacity constraints. In addition, there were workforce challenges particularly for ENT and breast care.

The Chief Executive noted the need for a cancer plan, improved governance and leadership. There was the opportunity to recruit to a post to support the Chief Operating Officer.

The Acting Chief Operating Officer reported that performance for breast cancer had deteriorated. In September 2021, 83% patients referred were seen within two weeks. However, this had fallen to 54% in October 2021 and 3% in November 2021. This was largely due to an increase in referrals, a reduction in waiting list initiatives and the support available from radiology which was challenged with staffing gaps. Patients were waiting four to five weeks from referral. A number of actions were being taken to improve performance. These included a change in the breast pain pathway and for appropriate patients to see a GPwSI ; insourcing staff for radiology and 'super weekends' in February 2022; and changes to Prism to request a physical examination before referral. Patients under the age of 35 years were being seen by another provider. For patients over 35 years old there would be additional lists to reduce the backlog. It would take a few months to redeem the performance levels. It was noted that performance for 2 week waits for breast cancer was challenged across the country (37% regionally and 52% nationally).

There followed a discussion about the reporting arrangements as the deterioration in performance had not been escalated fully. The Acting Chief Operating Officer was confident that the position could be redeemed but thought there were lessons to be learnt with respect to the governance for cancer.

Mr J McDonald, Trust Board Chair, considered there should be a plan for cancer care. In the meantime, there should be an update in relation to breast cancer performance (including a trajectory to forecast how the position would be retrieved); an assurance that the same issues were not happening elsewhere; and an assessment of the corporate infrastructure and governance for cancer care. **COO**

The Acting Chief Operating Officer noted that ENT was experiencing challenges in meeting demand for both elective and cancer activity. She had requested a piece of work to assess demand and capacity. The Acting Chief Operating Officer noted that there were opportunities to improve the patient pathways for elective ENT with approximately 50%of patients being discharged as not requiring hospital treatment after their first appointment.

The OPC Chair concluded the discussion noting the need to develop a plan for cancer identifying where the Trust aimed to be in three months, six months and a year. **COO**

Recommended – that (A) the contents of the report be received and noted,

to (B) to request a further report on breast cancer care, to include a trajectory to improve performance, for the next meeting. **COO**

and, to (C) develop a plan for cancer care. **COO**

04/22/3 Performance Briefing: Elective Operations

The Acting Chief Operating Officer presented paper D which updated the Committee on elective inpatient and day case (admitted) and outpatient (non-admitted) pathways, recovery of elective services, validation of waiting lists and diagnostic services.

The Acting Chief Operating Officer reported that 1,783 patients had waited over 104 weeks for treatment. A recovery plan had been developed in November 2021 to treat these patients and those who would breach the 104 week wait standard by 31 March 2022. This had identified 5,183 patients to be treated between November 2021 and March 2022. By the time of the meeting this number had reduced to c3,500 patients. The target to treat all these patients by the end of March 2022 would be challenging to achieve.

Mr M Williams, Non-Executive Director, OPC Chair, asked whether by focussing on the patients waiting the longest there was a potential for patient harm and whether the Trust had the right systems to manage waiting lists. The Medical Director outlined the system for clinically prioritising patients and confirmed that P1 and P2 patients, who were in greatest clinical need, were treated first. The remaining capacity was focussed on patients waiting the longest waits. In respect of the systems to manage waiting lists, the Acting Chief Operating Officer noted that patients waiting over 52 week were clinically reviewed. However, patients conditions could change and be escalated at a higher priority by primary care. The Chief Executive noted that it was not possible to provide complete assurance regarding waiting list management and that was why the Trust had secured external validation of the waiting list. The Medical Director added that there were discussions at a regional level regarding standardisation of the prioritisation of patients. UHL was considered to be an outlier in the number of P2 and P3 patients on the waiting list, particular for cardiology and this was being reviewed. The Acting Chief Operating Officer noted that the Trust had agreed to implement the Improving Elective Care Co-ordination Patient Programme which would support waiting list management. This programme had been developed by another trust and was funded by NHSI. There were also plans for the HIS system.

The Acting Chief Operating Officer reported that validation of the waiting lists was in progress. To date 41% of the waiting list had been validated. Elective Recovery Funding had enabled schemes to address the long waits. The Vanguard theatres were on site and a Community Diagnostic Hub would provide additional resource at the Leicester General Site. Attempts to secure mutual aid had been less successful. It was reported that ENT was challenged with respect to capacity and that this had been a challenge prior to the pandemic. An orthopaedic ward had been repatriated and additional medical beds provided at Glenfield Hospital. The Medical Director noted the problems for ENT were being experienced in other trusts and there were regional discussions about the workforce issues.

Mr M Williams, Non-Executive Director, OPC Chair, asked when the validation of the waiting list would be completed. It was noted that the plan was to complete the exercise by end of March 2022 as external support had been provided. The Acting Chief Operating Officer noted that the RTT team was small given the size of the Trust and that previous business cases had not been able to be supported. The Chief Executive noted that the need for such investment in non-clinical areas.

It was noted that the LLR Director of Planned Care had been appointed to the Committee this would support a system-wide approach to elective care. Consideration would be given as to how to report on system wide metrics for elective care. Mr J McDonald, Trust Board Chair, asked to see trajectories included in the reports.

The OPC Chair summarised the discussion and noted that need to address issues in the short-term and develop a more strategic system-wide approach to elective care.

Recommended – that the contents of the report be received and noted,

and (B) to include trajectories in future reports. **COO**

05/22 ITEMS FOR NOTING

05/22/1 Integrated Performance Report M8 2021/22

The Committee noted the Integrated Performance Report M8 2021/22. It was agreed that the report would be presented to future meetings for information acknowledging that the key issues would be highlighted in performance briefings presented for discussion.

It was noted that the Integrated Performance Report was received by the Quality Committee and discussed in the context of patient safety. The need to cross reference issues between the Board's committees was noted. It was agreed to have a standard item on the agenda to record those issues that should be brought to the attention of another Committee. **OPC Chair**

Resolved – that (A) the contents of the report Integrated Performance Report M8 2021/22 (paper E) be received and noted,

and (B) for future agendas to include 'issues to be referenced to other Committees' **OPC Chair**

06/22 ANY OTHER BUSINESS

The Committee thanked Ms D Mitchell for her service to the Trust. It was noted that Ms Mitchell had stepped into the role of Acting Chief Operating Officer at the most difficult time and had demonstrated great integrity and commitment to patient care.

07/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

There were no issues to refer to the Trust Board.

08/22 DATE OF THE NEXT MEETING AND FUTURE OPC MEETING DATES

Resolved – that the next meeting of the Operations Performance Committee be held on Wednesday 23 February 2022 at 10.00am (virtual meeting via MS Teams).

The meeting closed at 11.41am. Alison Moss - Corporate and Committee Services Officer

Cumulative Record of Members' Attendance (2021-22 to date):-

Voting Members

Name	*Possible*	*Actual*	*% attendance*
M Williams (Chair)	1	1	100
V Bailey (until February 2022)	1	0	0
B Patel	1	0	0
A Haynes	1	1	100

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*
J McDonald	1	1	100
H Hendley (from February 2022)	0	0	0
R Mitchell	1	1	100
D Mitchell	1	1	100
A Furlong	1	1	100
E Meldrum	1	1	100