Paper A

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF THE OPERATIONS AND PERFORMANCE COMMITTEE (OPC) MEETING HELD ON WEDNESDAY 27 APRIL 2022 AT 10.00AM, VIRTUAL MEETING VIA MICROSOFT TEAMS

Present:
Mr M Williams - OPC Chair, Non-Executive Director
Mr A Furlong - Medical Director
Dr A Haynes - Non-Executive Director
Ms H Hendley - LLR Director of Planned Care (non-voting)
Mr J McDonald - Trust Board Chair
Mr J Melbourne - Chief Operating Officer
Mr R Mitchell - Chief Executive
Mr B Patel - Non-Executive Director
Mr J Worrall - Associate Non-Executive Director (non-voting)

In Attendance:
Mr A Carruthers - Chief Information Officer
Ms A Moss - Corporate and Committee Services Officer

RESOLVED ITEMS

29/22 APOLOGIES

Apologies for absence were received from, Ms G Collins-Punter, Associate Non-Executive Director (non-voting) and Ms E Meldrum, Acting Chief Nurse.

30/22 DECLARATIONS OF INTERESTS

There were no declarations of interest.

31/22 MINUTES

Resolved – that the Minutes of the meeting of Operations and Performance Committee held on 27 March 2022 be confirmed as a correct record.

32/22 MATTERS ARISING

Resolved – that the Operations and Performance Committee matters arising log be received and noted.

33/22 KEY ISSUES FOR ASSURANCE

33/22/1 Performance Briefing: Urgent and Emergency Care

The Chief Operating Officer presented paper C, which provided updates on assurance and actions taken in relation to Urgent and Emergency Care. The report focused on performance, progress on the last month, and key actions and programmes of work taking place.

The Chief Operating Officer reported that the Trust had managed the Easter bank holiday well. The lessons learnt would be enacted in plans for the forthcoming bank holidays. In February 2022, monthly ambulance handovers over 60 minutes was at 28.28%. In March 2022, the 4-hour performance for the Trust was 55.3%, and the System's performance was 67.2%. UHL's national ranking for the month was 79th out of 113. It was noted that the metric for patients waiting over 12 hours in the Emergency Department would be revised in the coming months (date to be confirmed). The time would be calculated from the time of arrival and not the decision to admit. This would mean a significant deterioration in both the numbers classed as waiting over 12 hrs and the Trust's performance.

The Chief Operating Officer reported that the final feedback from the recent audit by NHSE/I was awaited. However, the initial findings indicated the i) the Emergency Department had a large number of

patients who should and could be managed elsewhere, ii) further work was required on Internal Professional Standards and speciality support, iii) co-locating emergency services would be beneficial, and iv) further development of the Same Day Emergency Care model would be beneficial. It was noted that these issues had been addressed in the Trust's existing plans, but the audit provided a greater focus. With respect to the co-location of emergency services, there were constraints on space, which presented logistical challenges. An Urgent and Emergency Care (UEC) Steering Group chaired by the Chief Operating Officer had been established to oversee the UHL action plan.

The plans for an Urgent Treatment Centre to be located on the Leicester Royal Infirmary site were being developed. It was anticipated the facility would be open in June 2022 and see 200-240 patients a day. Discussions regarding finance were being had with the System. Mr M Williams, Non-Executive Director, OPC Chair, asked where the staff would come from. The Chief Operating Officer reported that the initial plan was to outsource to Elite Services prior to a tendering exercise. It was felt that this was appropriate as the centre required primary care staff. The need to ensure the contractor was registered with the Care Quality Commission was noted.

Mr B Patel, Non-Executive Director, expressed concern about the Urgent Treatment Centre and the potential for increased demand as patient behaviour could change. The Chief Operating Officer acknowledged this was a significant risk but noted that it would not be advertised and would support the effective streaming of patients.

Mr M Williams, Non-Executive Director, OPC Chair, asked about the Internal Professional Standards and what further work was required. The Medical Director reported that there had been issues around how quickly the specialities took to respond to a request for an opinion from the Emergency Department and onward referrals. The standards had not been fully implemented for a myriad of reasons but largely because the specialities were struggling with capacity. Changes to the Nerve Centre had been made to track the process but there was work to be done to extract real time data. The Medical Director had worked with clinical directors to refresh the standards making them clearer and reflecting prior learning. The implementation of the e-prescribing module in June 2022 would assist. Further work would be done to enable the clinical management groups to embed the refreshed standards and an assessment made of what support would be needed to deliver the standards noting that it might have resource implications. For example, some specialities did not have an assessment area and there was a need to consider practical solutions to support clinicians. The UEC Steering Group and Performance Review Meetings would monitor the implementation of the revised standards. Mr M Williams, Non-Executive Director, OPC Chair, asked what the impact of these changes would be on the Emergency Department. The Medical Director responded noting that by ensuring specialities assumed responsibility for their patients in the Emergency Department this would improve clinical safety, and free up time for Emergency consultants to see new patients and improve patient flow.

Mr J Worrall, Non-Executive Director, supported the principle of co-locating the emergency services noting the difficulties with the Clinical Decisions Unit being based at Glenfield Hospital, but recognised the logistical difficulties of doing so. The Medical Director reported on plans to increase the presence of cardiologists in the Emergency department but noted the difficulties in providing dedicated space.

Mr J Worrall, Non-Executive Director, considered there was a need for immediate action by the System to ensure timely hospital discharges. Mr M Williams, Non-Executive Director, OPC Chair, agreed and noted the considerable impact most notably on elective care, finances and the East Midlands Ambulance Service. The Chief Executive considered that more needed to be done to ensure effective use of community beds and he hoped this could be resolved by the Autumn. Working with system partners to ensure timely discharge was the key priority. The Trust Board Chair reiterated the need for a primary care strategy.

It was noted that an external review of flow out of the hospital would be commissioned.

Approval was being sought from NHSE for a pre-transfer unit, which would release ambulances from waiting to hand patients over to the Emergency Department. The Chief Operating Officer proposed in the coming months that it might be useful for the system Senior Responsible Officer for UEC to be invited to OPC.

Mr M Williams, Non-Executive Director OPC Chair, summarised the discussion noting the key issues as the need to improve hospital discharges, concerns regarding increased demand for the Urgent

Treatment Centre, and patients waiting on ambulances.

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

(B) the SRO be invited to attend a meeting of the Committee. **COO**

33/22/2 Quality and Performance Cancer Report

The Chief Operating Officer presented paper D, which reported on performance based on the latest published dataset (February 2022) and an overview for the month of March and prospectively April 2022. The report also provided a more detailed focus for lung cancer.

The Chief Operating Officer noted the performance for the 12 cancer standards remained very challenged. However, there had been improvement in the performance for 2-week waits and breast cancer. Performance for 2 week waits for breast cancer was at 43.2% for March and likely to achieve 92% in April 2022. The Trust was forecasting to meet the national target (75%) for patients to receive their diagnosis within 28 days of referral in March 2022.

The performance for the 62-day waits was likely to deteriorate in April 2022. There had been a sustained increase in the number of referrals for cancer, which were significantly above pre-pandemic levels. In addition, the conversion rate had increased and there were challenges to surgical capacity. This trend was being seen elsewhere, however, a number of specialities, specifically lung, haematology and urology, were seeing a significantly higher conversion rate, Dr A Haynes, Non-Executive Director, asked why that was, and asked whether other trusts were using different pathways. The Medical Director agreed to review the position. **MD**

Mr J Worrall, Non-Executive Director, noted that whilst work was needed to review capacity, particularly for lung cancer, improvements could be made to processes. He asked whether the Trust was using the optimal lung cancer pathway. The Medical Director agreed that more could be done to streamline processes and that the focus would be on the most challenged areas first. He confirmed that the Trust was engaged with regional cancer pathways.

With respect to lung cancer, referrals had increased by 25% since the pandemic, and there were constraints on the diagnostic capacity, which spoke to the overarching issue of matching demand and capacity. It was forecasted that lung cancer treatment would remain challenged and changes to the workforce model were being implemented to mitigate the risks.

The Chief Operating Officer noted that there were action plans for cancer care at speciality levels and there would be a review of demand and capacity, and governance. Both a new Operational and Clinical leadership of cancer would be in post by mid-June.

The Chief Operating Officer concluded that there remained significant risk in cancer performance, and matching capacity to demand. There was a need to understand the position for each speciality and this would be the focus for the new leadership team. The action plans would need to be refined to provide greater assurance to the Committee regarding future performance.

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

(B) the Medical Director consider the reasons for the high conversion rates for lung, haematology, and urology. **MD**

33/22/3 Performance Briefing: Elective and Diagnostic Services

The LLR Director of Planned Care presented paper E, which provided assurance on the framework to manage the Referral to Treatment and diagnostic waiting lists.

It was noted that the Trust had set a target to reduce the number of patients having waited longer than 104 weeks, as at the end of June 2022, to 240. The LLR Director of Planned Care reported that it was unlikely that the target would be met. There was a variety of reasons including the pressure on emergency services, and the interim reconfiguration to move of the Intensive Treatment Unit. The Trust had been asked to add the patients who would breach the 104-week wait standard in July 2022.

This would add approximately 200 patients making a cohort of 1,800 patients to be treated by the end of June 2022. It was noted that the Trust was an outlier and was one of four Trusts in the 'Tier 1 National Support Programme'. This meant that the Trust was under increased scrutiny from the Regulator and able to access further support. The Intensive Support Team had visited the Trust and had made sixteen recommendations which were set out in appendix 1.

Mr J Worrall, Associate Non-Executive Director, cautioned about the reliance on mutual aid in the action plan, noting that other trusts were under pressure and unlikely to have additional capacity. He thought the action plan should prioritise day cases and the more challenged specialties, such as Ear, Nose and Throat. The LLR Director of Planned Care noted the point about the reliance on mutual aid and anticipated there was more scope to use the independent sector for specific patients.

The Chief Executive wished to set the challenge in achieving the 104-week wait target in context. He noted that there were many and long-standing problems, specifically around pressure on emergency care, demand and capacity for elective care and hospital discharges. He thought that the inability to ring fence beds for general surgery would hamper the recovery of elective care. Beds were needed for general medicine because of the pressure on emergency services and inability to discharge medically fit patients in a timely manner. He noted that whilst there was an immediate focus on patients waiting the longest, there was a need to address the growing demand and waiting lists for treatment which required a long-term strategy.

The Chief Operating Officer added that there was a balance to be achieved when prioritising different groups of patients. When a local trust had offered mutual aid for patients having waited the longest it had been agreed to send cancer patients instead. He assured the Committee that patient care was prioritised based on clinical need. The LLR Director of Planned Care added that patients were waiting the longest were regularly reviewed.

The Trust Board Chair asked about the role of the Integrated Care Board. It was noted that the Board offered an appropriate challenge to the Trust and was looking to provide support, for example, in considering incentive payments. The Chief Executive observed that the Integrated Care System was less developed in the East Midlands. The appointment of a LLR Director of Planned Care was a step forward in achieving a joined-up approach. The LLR Director of Planned Care added that there was regular communication about activity and improvement plans.

Mr M Williams, Non-Executive Director OPC Chair, asked about the response from patients with respect to waiting times. The LLR Director of Planned Care noted that recent communication with patients indicated that most preferred to be treated locally, despite the longer wait, and only a small minority choosing to travel further for treatment.

Dr A Haynes, Non-Executive Director, noted the need to understand the reasons for cancellations. The Chief Operating Officer noted there had been greater communication with those patients waiting the longest, but more could be done to communicate with other cohorts and the wider community. The Chief Executive agreed to hold a virtual engagement event to inform the public about elective services. **CE**

The LLR Director of Planned Care reported that the Trust had received confirmation to proceed to Outline Business Case and Full Business Case for £39m capital funding for an elective hub. Governance structures had been established and the business case was in development. The preferred option was to re-purpose the Brandon Unit on the Leicester General Hospital site, and the next step was to establish which specialities would benefit most. A short briefing had been shared via regional NHSIE for Ministers on how the elective hub fitted with the Trust's strategy for reconfiguration. Work to establish the hub would be reported to the Reconfiguration and Transformation Committee and the Finance and Investment Committee as well as via System governance such as the Integrated Care Board. .

Mr M Williams, Non-Executive Director OPC Chair, summarised the discussion noting the position in relation to 104-week waits and requested a report for the next meeting setting out the trajectories for all waiting lists.

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

(B) to hold a virtual engagement event to inform the public about elective care, and **CE**

(C) to receive a report on the trajectories for all waiting lists. **COO**

33/22/4 Patient Administration System Replacement Project Update

The Chief Information Officer presented paper F which provide assurance regarding the replacement of the Trust's Patient Administration System (PAS). It was noted that the replacement was part of the eHospital Electronic Patient Record (EPR) programme.

It was noted that the existing PAS had been in use for over 20 years and supported the Trust with the management of waiting lists, Referrals to Treatment, patient transfers around the hospital, and many other key clinical processes. However, there were elements of the system that did not link together and there were workarounds, manual systems, and an increased administrative burden. Several issues had been flagged recently, including patients lost to follow up and concerns regarding cyber security. Whilst it was known that PAS needed to be replaced, the EPR programme had prioritised projects of high clinical value. However, work had progressed on the PAS and the first version would be released in December 2022, with implementation early 2023 adopting an incremental approach. This would be the opportunity to improve processes and communication with patients. However, there was significant risk attached. The Chief Information Officer stressed the need for clinical engagement and a multidisciplinary project team to design out the risks. He highlighted the scale, scope and ambition of the project.

Mr M Williams, Non-Executive Director OPC Chair, Mr J Worrall, and Dr A Haynes, Non-Executive Directors, drawing on their experience of similar projects emphasised the risks to the project and asked whether there had been learning from other trusts. Dr A Haynes, Non-Executive Director, considered it important that there was a thorough risk assessment and that the Board was sighted to the risks. The Chief Executive agreed and considered that it was important that the project was clinically led and there was effective communication. The Chief Information Officer confirmed that the Trust was learning from other trusts, and there had been an internal audit of the governance for the project which would be reported to the Audit Committee. Mr M Williams, Non-Executive Director OPC Chair, concluded the discussion noting that it would be useful to have regular reports on progress and to understand the risk. **CIO**

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

(B) the Chief Information Officer be requested to provide regular reports to the Committee. **CIO**

34/22 ITEMS FOR NOTING

34/22/1 Integrated Performance Report M12 2021/22

The Committee noted the Integrated Performance Report M12 2021/22.

Resolved – that the contents of the report Integrated Performance Report M12 2021/22 (paper G) be received and noted.

35/22 ANY OTHER BUSINESS

There was no other business.

36/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF OTHER COMMITTEES

It was noted that the development of the Elective Hub would be reported to the Reconfiguration and Transformation Committee and that the financial approval would be referred to the Finance and Investment Committee as required.

The Chief Operating Officer noted that, should there be a significant change in the conversion rates for cancer, these would be reported to the Quality Committee.

37/22 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

It was agreed that the following issues be highlighted to the Trust Board at its public meeting on 5 May 2022:

- **104 week waits**
- **Elective Hub**
- **Urgent Treatment Centre**
- **Community beds**
- **Discharge of Medically Fit Patients**
- **Patients Administration System Update**
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38/22 DATE OF THE NEXT MEETING AND FUTURE OPC MEETING DATES

Resolved – that the next meeting of the OPC be held on Wednesday 25 May 2022 at 10.05am (virtual meeting via MS Teams).

The meeting closed at 11.56am

Alison Moss - Corporate and Committee Services Officer

Cumulative Record of Members' Attendance 2022-2023 to date:

Voting Members

Name	*Possible*	*Actual*	*% Attendance*
M Williams (Chair)	1	1	100
B Patel	1	1	100
A Haynes	1	1	100

Non-Voting Members

Name	*Possible*	*Actual*	*% Attendance*
J McDonald	1	1	100
G Collins-Punter	1	0	0
H Hendley	1	1	100
J Melbourne	1	1	100
R Mitchell	1	1	100
A Furlong	1	1	100
E Meldrum	1	0	0
J Worrall	1	1	100