

Public Trust Board Paper G1

Meeting title:	Public Trust Board				
Date of the meeting:	13 November 2025				
Title:	Escalation Report: Operations and Performance Committee 30 October 2025				
Report presented by:	Andy Haynes, Non-Executive Director (Acting Chair)				
Report written by:	Alison Moss, Corporate and Committee Services Officer				
	Decision/Approval		Assurance	x	Update
Where this report has been discussed previously	Not applicable				

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Yes, The BAF Activity Risks 2.

Impact assessment

- N/A

Acronyms used: BAF – Board Assurance Framework BGS - British Geriatric Society CDU – Clinical Decisions Unit CMG - Clinical Management Group ED - Emergency Department EMPCC - East Midlands Planned Care Centre FDS - Faster Diagnosis Standard	GIRFT - Getting It Right First Time IPR – Integrated Performance Report Linac - Liner Accelerator LRI – Leicester Royal Infirmary NOUS – Non-Obstetric Ultrasound OPC – Operations and Performance Committee SDEC- Same Day Emergency Care UHN- University Hospitals of Northamptonshire
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1. Purpose of the Report

To provide assurance to the Trust Board on the work of the Operations and Performance Committee (OPC) and escalate any issues as required.

2. Recommendation

That the report be noted.

3. Summary

OPC met on 30 October 2025. The meeting was quorate and considered the reports below.

4. Discussion Items

4.1 BAF

The Committee received the BAF, noting the risks within its remit. The Head of Risk Assurance highlighted the draft risk appetite statements.

4.2 Urgent and Emergency Care (in mitigation of BAF Risk 2(2))

The Committee was briefed on urgent and emergency care, highlighting areas of risk and actions being taken to address under-performance. Attendances for Adult ED are over plan and on plan for

Paediatrics ED. Admissions are over plan. Performance for the 4 hours waiting in ED remains on trajectory. Ambulance handovers have improved. SDEC is performing well.

The report covered the early discharge project, an update on the winter plan, proposal to expand inpatient capacity, and possibilities for reconfigure sites to expand emergency capacity.

The Committee expressed concern about the ICB's proposal to decommission a number of services. It sought assurances with respect to the Quality Impact Assessments and governance route.

OPC requested further reports to cover comparative rates for ambulance conveyances for local trusts and criteria-led discharge.

The Committee highlights to the Trust Board for information: the continued high attendances which are impacting on performance and the ICB proposals for dis-investment.

4.3 UHL- UHN Access Strategy (in mitigation of BAF Risk 2 (2))

The Committee noted the joint work with the UHN to improve access to services.

4.4 Elective Care and Diagnostic Services (in mitigation of BAF Risk 2 (2))

The Committee was briefed on elective care recovery progress, highlighting areas of risk and actions. The exception reports, key metrics and trend information are referenced in the IPR.

Performance for long waits is challenging. The Trust has been placed in Tier 1 by NHSE due to the 65-week wait position. The trajectory for 0 patients having waited 65 weeks or more is by 21 December 2025. However, this is very dependent on key services delivering additional activity whilst balancing pressures on emergency care. Activity is increasing in the EMPCC. It is expected that the Centre will achieve its trajectory by March 2026 but will not make up for the lost activity since it opened.

The Committee noted outpatient productivity work and digital transformation around ambient dictation and call and booking systems.

OPC was briefed on the performance of diagnostic services. The number of patients waiting more than six weeks for a diagnostic test reduced and the number waiting more than 13 weeks slightly increased. The main pressure was in relation to NOUS and Endoscopy. Improvement for both these areas is expected next month. It is anticipated that performance will be on plan by March 2026.

The Committee requested that further reports address the assumed benefits of automation, theatre productivity and ophthalmology.

The Committee highlights to the Trust Board for information: that NHSE has placed the Trust in Tier 1 for the 65 week waits position and the expectation of meeting diagnostic targets by the end of the year.

4.5 Cancer Operational Performance Report (in mitigation of BAF Risk 2 (3))

The Committee was briefed on cancer operational performance. The Trust's performance is in the bottom quartile which is largely down to the loss of locums in three key tumour sites. Actions to recover the position are having an impact for the performance against the FDS and the 62-day wait standard.

There remains a risk in relation to performance for breast cancer, specifically first appointment times. Whilst there are plans in place it will take longer to resolve.

OPC noted the loss of funding from EMCA. Whilst the Trust has agreed to pay for some Cancer Nurse Specialists it was only for one speciality and there may be a case for others.

OPC took assurance from a deep dive into Radiotherapy noting the impact of the new linac.

The Committee highlights to the Trust Board for information: the deterioration in performance; that good mitigations are in place with an impact expected soon; assurance from the deep dive on Radiology; and the risk in losing Cancer Nurse Specialists.

4.6 Getting It Right First Time (GIRFT) – Frailty (in mitigation of BAF Risk 2 (2))

OPC was briefed on progress in addressing recommendations from GIRFT/BGS for the management of patients living with frailty in an acute hospital.

The Frailty Action Board has been established with representation from each CMG. Frailty and delirium screening tools are available on NerveCentre and there is work to improve the number and quality of assessments. Data dashboards improve visibility of frailty-related metrics. There are plans to create a non-ambulatory fragility fracture pathway and enhance perioperative pathways for frail patients. There is work with the System to strengthen services like 'call before convey' and the frailty virtual ward.

The Committee supported the plan and asked for a report back in six months.

4.7 Transformation of Acute Cardio-Respiratory and Medical Services (in mitigation of BAF Risk 2 (2))

OPC was briefed on progress in transforming the current Urgent and Emergency Care pathways for Cardio-Respiratory and General Medicine patients. A hybrid model has been agreed to provide some medical input into the CDU at Glenfield and some cardio-respiratory input into the LRI. The first step is to convert a cardiology ward to general medicine at Glenfield Hospital by December 2025. The second step is for cardio-respiratory in-reach to be taken over by acute medicine. Additional acute physicians will be recruited to look after cardio-respiratory patients waiting in ED.

The plan for next winter is to have some acute physicians working alongside cardiology and respiratory in CDU. This will release cardio-respiratory resource for in-reach into LRI. The longer-term goal is to consolidate all the medical wards at Glenfield Hospital.

5. Information items

- Integrated Performance Report M6 2025/26