The Leeds Teaching Hospitals NHS Trust

Operational Transformation Strategy

2022-2027

Contents

1.0 Foreword

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Chief Executive

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Chief Operating Officer

Welcome to our Operational Transformation Strategy, an ambitious plan to achieve our vision to be the best for specialist and integrated care.

We strive for Leeds Teaching Hospitals NHS Trust to be a great place to work and an outstanding place to receive care. We are home to a vast range of services ranging from leading national and international specialist services to high quality care and treatment for patients in Leeds and West Yorkshire. With 20,000 staff, seven sites, 2,000 hospital beds and 1.6 million patients every year, running a Trust is a huge and complex operation.

At the time of writing this strategy, health and social care is facing huge operational challenges. We have increasing demand on our services, significant backlogs in elective care, areas of workforce shortages and need for investment in our physical and digital estate. But we are convinced that our fantastic staff, strong partnership working and opportunities for innovation mean that we are as well-equipped as anywhere else in the NHS.

Our ambition is to improve the quality and timeliness of care whilst delivering first class patient experience and improving outcomes. This Operational Transformation Strategy, with its five Transformation Programmes, describes how Leeds Teaching Hospitals NHS Trust is utilising the five Leeds Way values - Patient-Centred, Fair, Collaborative, Accountable and Empowered - to take on these challenges, and become the best for specialist and integrated care.

2.0

Strategic context

Leeds Teaching Hospitals Trust's (LTHT) overarching vision is to be the best for specialist and integrated care and as such we work as a system partner to provide person centred care in our hospitals, in the community, and at home.

We acknowledge our role as an anchor institution and as a leader both within Leeds and also at a regional level as well.

Integral to this vision is the development of the Leeds Children's Hospital within its new purpose built facilities, building upon its reputation as one of the UK's largest specialist children's hospitals and delivering care and treatment across 27 specialties for children from birth to young adulthood and beyond, with outstanding outcomes.

over **20,000** staff

7 hospitals

GOOD CQC rating

£1.4 billion budget

1.6 million **patients** treated each year

221,000 **emergency patients** per year

over **144,000** **outpatient appointments** in the Leeds Children's Hospital per year

over **10,000** **surgical procedures** undertaken at Leeds Children's Hospital each year

2.1 Trust Strategy

In order to meet our strategic aims we have a series of objectives that we are committed to, and all programmes of work developed will contribute to the delivery of those objectives.

1. Outstanding

We will achieve **Care Quality Commission (CQC) Outstanding** at our next inspection.

2. By 2024 we will have the **highest staff engagement score** nationally.

3. We will work with our partners to provide **person-centred care** across care settings, delivering more care closer to home.

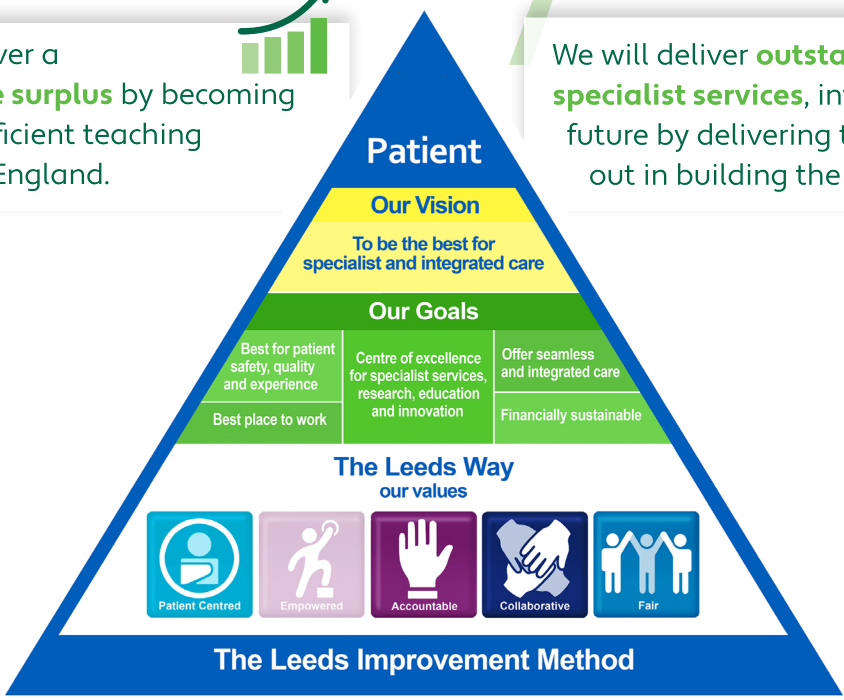
4. We will deliver a **sustainable surplus** by becoming the most efficient teaching hospital in England.

This strategy sits alongside other organisational strategies such as Quality, Workforce, Estate, Digital, and Clinical Services in supporting the delivery of the Trust five year plan. As such the priorities outlined align to the Trust annual plan and we will undertake a yearly review to ensure progress. We plan a fundamental review in 2024/25 to assure us of progress as we move closer to the opening of the new hospitals at the LGI.

5. We will provide **excellent education, training and development** so that people are skilled to do their job and realise their full potential.

6. Every patient will have the opportunity to **benefit from and participate in research**.

7. We will deliver **outstanding specialist services**, investing in our future by delivering the vision set out in building the Leeds Way.



2.1.1 People's Voice

During the pandemic, LTHT worked alongside partner organisations to hear about what matters to them and how to improve their experience of care. This work has been captured as part of a programme called **'How Does it Feel to Be Me?'**, and also by the **Leeds People Voices Group**.

From this, we know that people using health and care services consider 'Communication, Co-ordination and Compassion' as fundamental to a positive experience. They have told us, for example, that good communication should be:

- Person-centred involving the person receiving care and their family carers if they wish.
- Clear and jargon-free, delivered in a way that people will understand.
- Timely.
- Compassionate.
- Sensitive to the content, and how it will be received.
- Accessible - people should always have their communication needs considered and steps should be taken to meet those needs.
- Not rushed - time should be given to check understanding and for people to ask questions.
- Informed, accurate and trusted, delivered by skilled staff supported in trusted service.

The ambition to make person - centred care a Trust reality must be influenced by listening to the experiences of people and challenging ourselves to reset and transform services. We need to use the learning from these services to inform the way forward, including (for example), ensuring that all services consider the range of communication needs of patients, in line with the Accessible Information Standard and are able to communicate in a way that works best for individual patients and their families.

By listening and engaging with the public we serve we will be better positioned to deliver outstanding care and patient experience with world class outcomes.

There are examples of what patients and their carers have said are important to them throughout this document.

> *"You feel like you are getting your voice heard at last, there's somebody there that actually cares about what is going on and about how you feel. I feel like I'm being listened to."*

2.1.2 Person-centred Care

Person-centred care and support means working alongside our patients in the planning and delivery of services and listening carefully to what matters to them. It takes account of people's different backgrounds and needs and enables those who are at the greatest risk of poor health to benefit the most. NHS England have introduced the Comprehensive Model of Personalised Care for which Integrated Care Systems (ICS - a collaboration of health care organisations (*more in section 2.5.3*)) are held accountable, bringing together six, evidence-based components or programmes, each of which is defined by a standard set of practices.

These are:

- **Shared** decision making.
- **Personalised care and support** planning.
- **Enabling choice**, including legal rights to choice.
- **Social prescribing** and community-based support.
- **Supported self-management.**
- **Personal health budgets** and integrated personal budgets.

In Leeds the Health and Care Partners have agreed five principles outlining how person-centred care and support can be put in practice.

5 key principles

Focussing on addressing health inequalities (eg a focus on health literacy).

Effective communication and good quality conversations (eg embedding shared decision making).

Systems working together delivering holistic co-ordinated care.

Skilled and confident workforce (empowered to have 'better conversations').

Respect for peoples values, preferences and needs (recognising that they are the experts in themselves).

We have a number of examples of how we are embedding the principles and have been implementing shared decision making specifically within Oncology. The ambition is now to move deeper with this in line with National Institute for Health and Care Excellence (NICE guidance) and ensure all services are systematically delivering.

2.2 Guiding Principles

Section 2 will highlight the context and challenges we as a provider of specialist and integrated healthcare face as we emerge from the pandemic. The focus of the programmes of work in this context will be:

- Improving the quality of patient experience.
- Improving outcomes for patients.
- Improving timeliness of care.
- Improving the way we design and use our resources to increase the offer for those using our services.
- Reduction in health inequalities.
- LTHT is the best place to work for our staff.
- LTHT becomes the best partner within the city, WYAAT and ICS.

> *"Got to LGI and despite a long wait for the actual procedure, the staff were fantastic - they were kind, caring and friendly and couldn't do enough for me which I greatly appreciated."*

2.3 Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. The Trust recognises that we have a significant role we can play in tackling health inequalities in three main ways:

As a secondary care provider

As an Anchor Institution
across employment, procurement, environment, and assets etc.

As a system partner
in the Leeds Health and Care Partnership and the wider West Yorkshire Integrated Care System (WY ICS).

The Joint Strategic Assessment (JSA) provides a holistic and reliable source of data and analysis about key demographic, socio-economic and health and wellbeing in the city.

The 2021 Leeds JSA highlighted that the city's population has continued to become more diverse, in terms of age (with a large increase in the older age groups) and countries of origin and ethnicity. In Leeds 26% of the population now live in the 10% nationally most deprived communities. Almost 24% of children (under 16s) are estimated to live in poverty. There is an increase in the gap between 'deprived' Leeds and Leeds overall for infant mortality, female life expectancy is stagnating, and the gap between deprived Leeds and the city average widening.

Although as Marmot highlighted in 'Build Back Fairer', many of the answers to this are not within our gift, we can still make a significant contribution through our role as an anchor institution, as a civic partner and as a service provider.

We are currently progressing the detailed development of our Health Inequalities Strategy, which will use as its framework the Leeds Tackling Health Inequalities Toolkit.

> *"From start to finish visiting minor injuries, to my surgery and aftercare in physio at the LGI, I was cared for in a way that truly made me feel looked after. For someone who has health anxiety, the staff really helped to calm me before and during my first ever surgery."*

2.4 Using the Leeds Improvement Method (LIM)

With learning taken from our partnership with the Virginia Mason Institute (VMI), we move into an exciting new era with the Leeds Improvement Method (LIM).

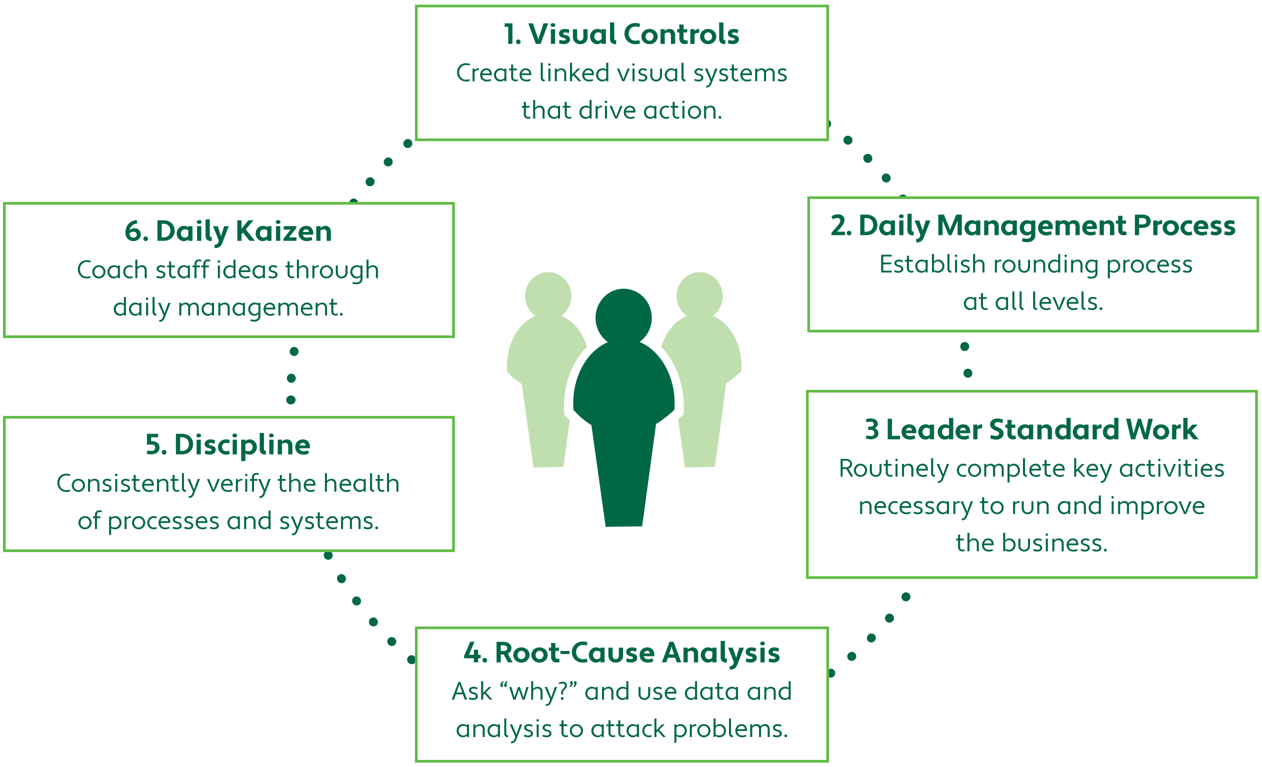
We wish to continually learn and adapt our approach from our experiences, to become an outstanding organisation where continuous improvement is at the heart of everything we do.

This LIM strategy will see Leeds Teaching Hospitals embed our philosophy of continuous improvement, alongside adopting the principles of daily management methods, encouraging the relentless removal of waste from our processes.

The LIM focusses on improving quality, safety and experience for patients and staff, through the use of a variety of improvement tools, training methods and leadership strategies underpinned by respectful behaviours.

The LIM strategy incorporates developing all our staff with the skills and capability to deliver meaningful changes in their services, increasing value and reducing waste. It equips senior leaders and executives to better understand the current challenges in the local system and determine our key priority areas.

LIM works best when people at the point of care, those engaged directly in the work, are empowered to develop and test changes and use balanced local feedback data sets to make improvements. Where something works, we will support the spread and scale up of improvements across the Trust, recognising that local adaptation and testing in different locations may be required.



In addition, we will actively be seeking to involve more patients, carers and partners in our improvement work, programmes and priorities. We will support our Clinical Service Units and Specialties to plan their improvement priorities in partnership with patients and families, and support individual members of their staff and their teams.

The NHS and the challenges it faces are continually changing and therefore our LIM strategy will be dynamic and evolve to be able to accommodate the new issues that can develop, and priorities that change over time.

Our ambition is for Leeds Teaching Hospitals to:

- build a culture of continuous improvement across the organisation
- never stop improving our services and
- be an organisation with continual learning and improvement genuinely at the heart of everything we do.

In most instances our teams know what works well and what has the biggest impact on patient care. By systematically and routinely following the principles of daily management we will support those teams to consistently deliver world class care for patients.

Our aim is to deliver world class equitable outcomes in specialist services, providing leading edge innovation in diagnosis, treatment and care. Our strong partnership with the University of Leeds and wider partnerships with research and innovation, commissioners and other specialist centres all contribute to this aim. We are committed to playing our role in reducing health inequalities as a service provider, an anchor institution and a civic partner.

In order to support the delivery of these ambitions it is imperative that we work with our partners in the health and care system to plan, train and develop our people, ensuring they have the right skills and values to deliver outstanding care now and in the future.

Throughout all of this work the LIM, including the use of our Quality Improvement methodologies, will be the 'go to' way we change our work. Embedding daily management, reducing waste and adding value will be the golden thread throughout.

2.5 Influences

There are six main influences that have, or could have, an impact on our ability to deliver our organisational strategy and the care we aspire to for our people. Each of these factors are so significant that they need to be considered in the context of our approach to operational improvement and transformation.

We will strengthen the systematic use of data to inform our decision making using well renowned sources such as GIRFT (getting it right first time), Model Hospital and Dr Foster.

These influences are:

Workforce challenges exacerbated by the pandemic. This means we will need to develop workforce solutions with new roles developing and at a cross organisational level support better integration and meet the challenges faced by community care partners.

Financial pressures including the delivery of waste reduction schemes will necessitate more innovation in the delivery of services.

We have to, and will, become more productive as our services reset, and this will allow us to treat more patients and reduce waiting times.

The ongoing impact of Covid on the delivery of all services and the exacerbation of pre-pandemic challenges.

The ambition to be the most efficient secondary care organisation in England in order to meet the capacity afforded by Building the Leeds Way and in support of the delivery of healthcare by all our services.

The impact of the introduction of Integrated Care Systems in West Yorkshire and the Leeds Health and Care Partnership.

"I'd like more input from medical staff to make me aware of exactly what my husband is going through. They're using such big words, you know way above your head, and I wish I didn't need to ask what it means."

2.5.1 Impact of COVID-19 - Stabilisation, Reset and Recovery

The pandemic has caused social and economic change on a scale not seen in our lifetimes, and its lasting medium and longer-term effects remain unclear, particularly on issues such as mental health and wellbeing. We do know the direct effect there has been on human life, represented by the significantly higher excess deaths as a direct result of Covid when compared to the 2015-2019 average. We also know that there has been a clear disproportionate direct impact of the virus on older people, with the majority of hospitalisations and 93% of all Covid deaths in Leeds having affected people over 60. We also know the virus has exposed existing inequalities with case rates higher in areas and communities already experiencing disadvantage.

The impact of Covid on morbidity, unplanned care for other urgent conditions, planned care and wider mental wellbeing, both for our patients and our staff, is still unfolding. However we have seen significantly higher attendance at A&E leading to long waiting times, high bed occupancy rates and a significant impact on workforce pressures.

During this time we have seen within the Trust, the city and the wider region, the delivery of services being transformed in response to the challenges of supporting people. Partnership working within LTHT, through the collaboration between different clinical services, has been exemplary, but we wish to go further. During the pandemic the voice of the people in shaping change was not as prominent. We aspire to change that and do better in patient and public involvement.

Patients had waited too long prior to the pandemic and this situation has deteriorated, but we have ambitious and realistic plans to deliver improved timeliness of care for our longest waiting patients in the future. Pressures on adult social care and community care provision had a significant impact on LTHT, with resulting bed occupancy routinely at 96-99%. We will build on the current work in the city to change the intermediate care offer to patients and reduce the numbers of patients staying in hospital beyond 21 days.

The challenges we have also bring huge opportunities for improvement, to transform our services and maximise the use of our estate to the advantage of our patients without further impact on the health and wellbeing of our people, who have been the backbone to the NHS' Covid response. In all our work, we must ensure that the health and wellbeing of our people is a priority and is central to our actions and plans.

As we emerge from this pandemic we need to re-energise our approach to change and support widespread staff engagement in change in the future.

2.5.2 Building the Leeds Way (BtLW)

This is an exciting time to work at LTHT, with the biggest single hospital building project in the UK being undertaken here, including a new Pathology building at SJUH due to open in 2023 and the new adult wing at the LGI and the flagship purpose-built Leeds Children's Hospital, both due to open in 2027. Over the lifetime of this strategy the Trust will develop new ways of working to support the move of services into these fantastic new facilities.

The buildings will be designed to offer modern, person-centred healthcare based on the most advanced treatments, technologies, innovation and research. It is an ambitious, long-term development that will change the way we think about hospital care but these developments also require us to radically transform the way we deliver service.

These new buildings will be built to be flexible and be able to respond to ever evolving changes in healthcare delivery. Much of our estate will not be affected by the new builds. In the context of the Trust's Estate Strategy and Hospitals of the Future Project however, our programmes of work will actively consider the best use of Trust estate, such as how we can maximise the opportunity for cold and hot wings (elective and non-elective) or buildings in the context of maximising efficiency for planned and unplanned flows.

When one considers the predicted growth in demand, the impact of Covid and how we think about the use of estate in the context of a pandemic response, we will need to become the most efficient secondary care organisation in England to achieve our ambitions.

In order to release the benefits from BtLW our approach will focus on three key areas:

Maximise opportunities
to deliver new service models.

Reduce the demand
for inpatient and increase the capacity for day cases.

Build on exisiting model
of utilisation of our facilities beyond the traditional five day a week model in outpatients, theatres and diagnostics.

2.5.3 The Healthy Leeds Plan

The Healthy Leeds Plan is the City of Leeds' plan for the health and care systems contribution to health and wellbeing in Leeds. It aims to improve the health of the population of Leeds in the following ways:

- Focusing more of the city's resources and attention on supporting people to live, age and die well.
- Ensuring its services and resources are focused on reducing health inequalities.
- Investing more resources in prevention and personalised proactive care - often (but not always) resulting in more activity and care taking place in community settings including people's homes.
- Ensuring that services work with people as equal partners in their care, and that services are delivered in a way that is focused on what matters to people.

The Healthy Leeds Plan goes hand in hand with our 'Hospitals of the Future' Programme.

It sets out the strategic indicators for each part of the population (frailty/long term conditions) and Care Boards (eg cancer/maternity/planned care and the Children's population Board). For each indicator there is an ambition (where we can measure it) to be as good, if not better, than the England average and to reduce the health inequalities between Leeds and deprived Leeds by 10%.

2.5.4 Integrated Care across Leeds and West Yorkshire

We will continue to build on our partnerships, both within the city and across the region, to support the delivery of high quality and equitable healthcare for all. We will do this as a part of the West Yorkshire Health and Care Partnership, and as a contributor to its newly established Integrated Care Board (ICB). As an NHS Trust we have a new "duty to collaborate", with the aims of:

1. improving the health and wellbeing of people.
2. tackling inequalities.
3. improving the quality of services provided or arranged by partners or other relevant bodies.
4. ensuring that places act in a way that results in sustainable and efficient use of resources by both partners and other relevant bodies.

The Leeds Place Based Partnership is a committee of the West Yorkshire ICB. The Leeds Health and Care Partnership has set out its ambitions for the outcomes to achieve by health and care over the next five years within 'Healthy Leeds - our plan to improve health and wellbeing in Leeds'. The aim is that through the Healthy Leeds Plan models of care are created for the city which drive health improvement and reduce health inequalities, meets future demand, and can also be delivered within the future estate footprint. To support this the city is establishing Population and Care boards, using population health planning to collectively allocate resources to achieve agreed outcomes. This will include a systematic use of population health management approaches and ensuring people's voices are at the heart of decision making.

Responding to the changes at ICS level, we will build on our existing partnerships through the West Yorkshire Association of Acute Trusts (WYAAT), for example by seeking opportunities to accelerate our elective care recovery across West Yorkshire. We will continue to work to identify and support fragile services across WYAAT by reviewing the sustainability of services, supporting network solutions and having shared accountability.

Working with partners in Leeds we are committed to furthering our vision to be the best for integrated care by improving health and reducing health inequality. This will be an important factor when improving services, through building on the excellent work with primary care and other partners in response to the Covid pandemic.

Our services will need to become attentive to the personal needs of healthcare users. Evidence based healthcare and digital applications will promote responsive and interactive health management and thereby contribute to independent living.

Technology and promoting information flow will also enable collaboration between clinicians. As a teaching hospital, with many specialised services, we will increasingly need to support effective clinical networks.

Integration in Action

In May 2021 a new campaign 'Shapeup4surgery' was launched, to encourage everyone needing surgery to get in shape, both physically and mentally, to ensure a quicker and faster recovery.

SHAPE up 4 surgery

As part of the campaign greater links have been established with our city partners to provide preventative healthcare and lifestyle support in the community, local to the patients. We have also linked with charities who are providing activities to our most deprived communities, to encourage and support individuals to become more active whilst waiting for their surgery.

Integration in Action

We are committed to integrating pharmacy and medicines optimisation as described in '*Leading integrated pharmacy and medicines optimisation (IPMO) Sept 2020; NHSE&I*'. The integrated pharmacy model across Leeds and West Yorkshire will be at the heart of, and support, ICS cross system leadership through the ICS Pharmacy Leadership Group (PLG).

Workstreams

An integrated pharmacy model will breakdown silo working, fragmentation and duplication in the current system, with a material impact on our patient's healthcare experience. There are six overarching workstreams identified as key priorities for the West Yorkshire ICS IPMO programme:

1. Greener Sustainable NHS through reduced medicines wastage.
2. Antimicrobial Stewardship (AMS) to ensure effective use of antimicrobials, maximising resources and preventing resistance.
3. Overprescribing aiming to reduce the medicine burden on patients.
4. Better Use and Availability of Medicines Expertise and the Pharmacy Workforce.
5. Reducing Avoidable Harm through safer medication practices and reduction in avoidable medication associated harm.
6. Preventing Ill Health and Optimising Medicines Pathways through:
    a) Promotion of Self-Care to improve health outcomes.
    b) Priority Pathways to improve population health and reduce inequalities.
    c) Best Value from Medicines to improve health outcomes and obtain best value from medicines.

> *"The only person who really knows your condition is yourself, because no two people are the same. So, it helps you to look after yourself and learn about your condition because the more you learn about your health, the better decisions you make about it."*

3.0 Transformation Programmes

As we have adapted our services in response to the pandemic, a number of innovative and novel approaches to the delivery of healthcare were adopted and have become embedded.

Many of these changes have become embedded as examples of excellent practice and we will continue to support the scale and spread of this across the Trust. This will help as we continue to recover from the impact of the pandemic but as importantly will help us reshape how we deliver services in the future for the benefit of the people we serve. How we do that will be through the five Transformation Programmes described on the following pages.

3.1 Oversight of Transformation Programmes

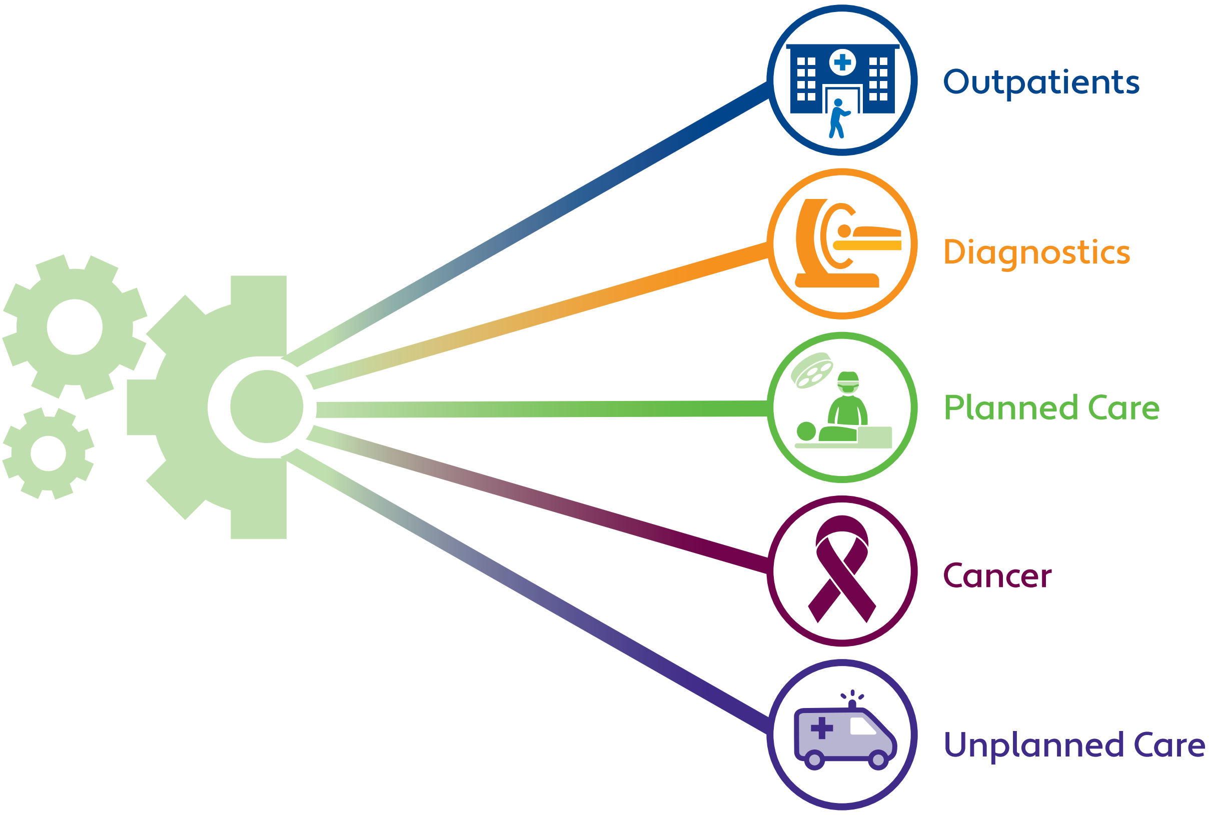
The Trust will support the ambition to be the best for specialist and integrated care, including being the best hospital for children and young people through the Operational Improvement and Transformation Programmes. Oversight of these Programmes will be via the Transforming Services Group (TSG). The role of the TSG will be to deliver this strategy by ensuring that the Programmes are set up to succeed, with a clear understanding of the priorities and a passion to deliver the changes needed to support our ambitions for patients and staff.

Each work programme has a Board comprising clinicians, managers, Kaizen Promotion Officer and BtLW team members, as well as an aspiration for greater primary care and wider system representation to ensure connectivity and peer challenge and innovation.

As a fully integrated Adult and Children's Trust these Programmes of work will be embedded within all our Adult and Children's services. In recognition of the specific link for Childrens' and Maternity services, separate groups have been established to focus the implementation of the work of the five programmes in those areas.

These Programmes will be open and innovative in their approach. The Senior Responsible Officers (SROs) and team members are encouraged to think creatively about the pathways patients take, the best use of estate to ensure these pathways are optimised, and to learn from best practice sources such as GIRFT, Model Hospital and Royal Colleges. Routine and regular evaluation of progress will be made through Model Hospital Reviews. The Programmes will work collaboratively with each other and community partners in order that we have integrated and non-contradictory plans, which keep the health and wellbeing of our people at the forefront of decision making.

Transformation Programmes



Each programme has developed its own set of Key Performance Indicators (KPIs) which are reported to the TSG routinely and inform members, as well as the Hospitals of the Future Board, of progress.

A review of these KPIs against Model Hospital data will be built in to the governance and oversight process during 2022/23.

"The whole admission and everything seemed different this time. Staff listened a lot longer, were extra caring and you felt it."

3.1 Outpatients

The number of outpatient appointments and complexity of patient care and treatment at LTHT has changed over the last five years, and the need to transform the traditional outpatients model has been accelerated following the impact of Covid.

With patients at the centre of everything we do, outpatients is often the first or most frequent interaction our community has with LTHT. As such each interaction needs to be of value. As with all services, patients have waited too long to access outpatients and the work of this programme will improve the timeliness of appointments which we know will have an impact on improving outcomes for patients. There will continue to be a need for face-to-face appointments, but where it is safe and more convenient for patients to access services remotely this will be pursued.

Outpatient services at LTHT have required a change of approach to maintain timely patient care, safety and experience and these approaches will be embedded as best practice. The centralisation of much of the outpatient service at the LGI will determine that a more centralised, service-responsive model of booking is adopted that ensures full oversight and transparency of how this caqpacity will be utilised in the future.

LTHT Outpatients will deliver to patients and their families and carers:

- **The right treatment.**
- **By the right professionals.**
- **At the right time.**
- **With specialist and sub-specialist care as close to home as possible.**

“I like to be spoken to. I want staff to say ‘this is the situation, this is what we are doing, this is what we need to do at this stage and after this has happened we’ll look at it again. Then I’d like to know when that will happen. I need that news for me to make my decisions.”

Outpatients

In many situations care will be delivered virtually without a patient needing to leave their home. The outpatients departments will provide a state of the art, patient-centred experience for specialist and routine outpatient care. Only patients who need to travel to the hospital sites, or who wish a face-to-face consultation will need to be seen in person.

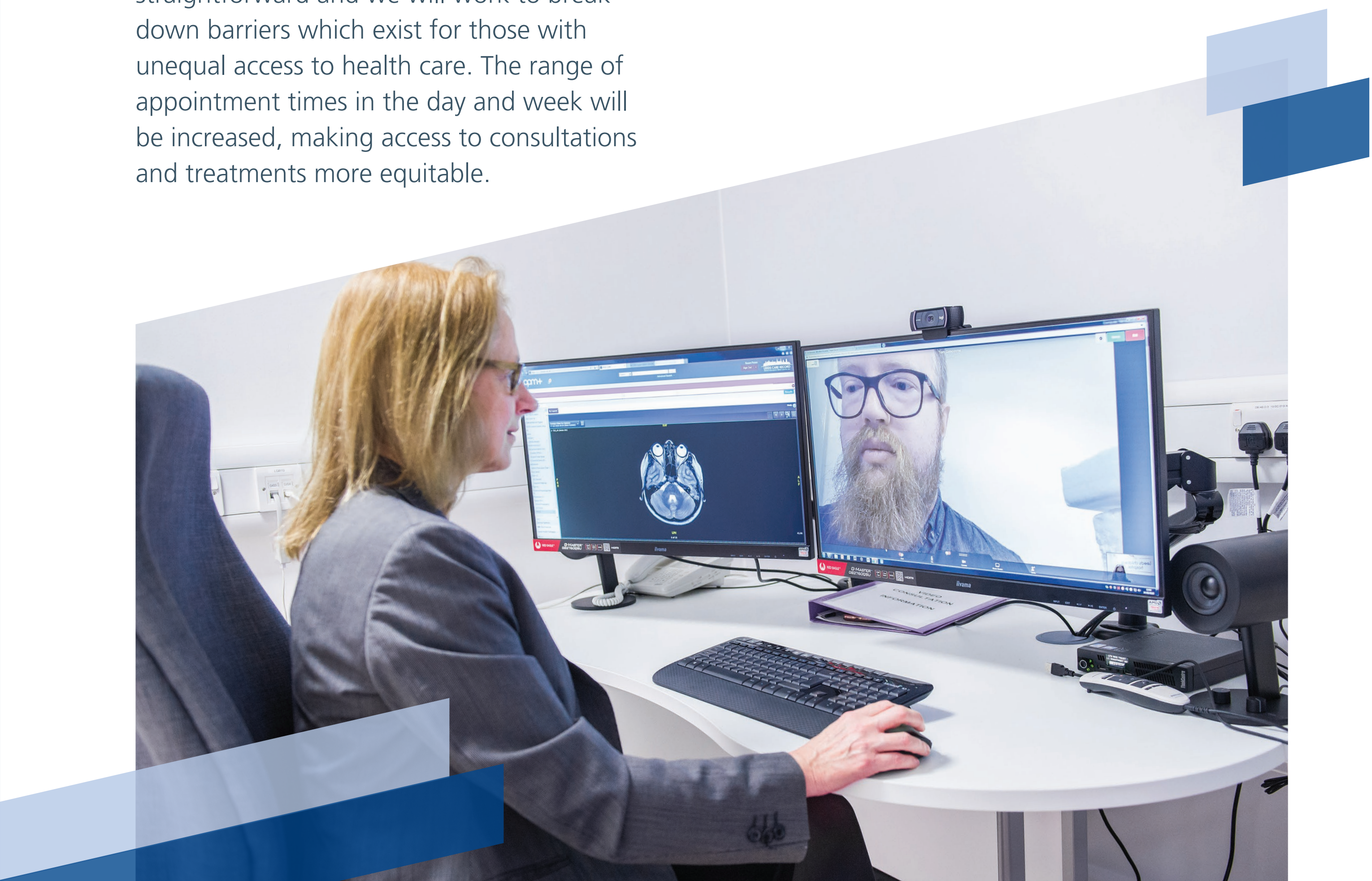
For those patients who visit our outpatient facilities, a bespoke and reassuring environment will meet anyone who enters.

The use of digital technology will redesign arrival, departures, booking investigations and further visits. Volunteers and staff will remain visible and approachable as a very human presence in the departments. We will train and teach future generations of health care professionals in our departments.

Physical access by all patients will be straightforward and we will work to break down barriers which exist for those with unequal access to health care. The range of appointment times in the day and week will be increased, making access to consultations and treatments more equitable.

Transformation will allow us to allocate our resources differently, to support better integration of primary and secondary care, using workstreams such as Advice and Guidance and Patient Initiated Follow-Up. Regardless of pathway, best in class digital technology will be the enabler and transformation will be achieved through workstreams which will be enhanced by Digital Hub, Robotic Process Automation (RPA) and Room Scheduling tools.

Embracing a user perspective, seeking and harnessing patient feedback, and working with patients and colleagues to co-design processes will be essential to developing truly high-quality outpatient service delivery in the Trust.



5 key principles

The right structure

We will work to create a system that meets our users' needs by including them in the conversation to embed and re-design our processes.

By taking a user view and co-designing processes and ways of working, we aim to create real change for patients and LTHT colleagues.

The new hospital will see specialties co-located. This change will allow us to understand and design an optimal staffing structure to support services and allow for agile devolved decision-making, underpinned by a formal structure and written processes that support the ability to deliver innovation to all outpatient settings.

Inclusive delivery

For some patients, access to care is intricately bound up with systems that are not intuitive and can create barriers for them to access their care.

Patients with additional needs can find it particularly challenging to understand their care because communications or systems are not accessible or designed for patients with a range of needs and digital skills.

We will design services that are inclusive for people with a range of preferences, and those who have additional needs.

Digital access

Digital will play a pivotal role in the transformation of the LTHT outpatient service.

We have started to embed our move to our digital front-door at LTHT, and our ambition for Year 1 of our programme will deliver more gains to progress this.

Developing capabilities to tailor communication to users' needs, and allow two-way flows of information, will support patients to feel more engaged and empowered and improve their pathway experience.

The right communication

Outpatient communication will take place via systems that allow services and patients to communicate with each other in an improved way, based on their preferences, and enabling them to access information and support when they require it.

We will use the Leeds Improvement Method to focus on removing waste and maximise opportunities to improve patient experience along the pathway.

A multi-skilled and inclusive team

Our services rely on our Outpatient workforce and as well as growing this team, we want to retain them and offer new skills and roles across the pathway, so we have a multi-skilled and inclusive workforce who can deliver outpatient services for the future.

We will also look for opportunities to grow our own, using the Apprenticeship Levy as well as scoping setting up an Outpatient Academy - a service that delivers training, signposts education opportunities, ensures quality standards are being met, and gives our staff the skills and competencies they require for their current and future roles.

"For something like this, a video call was just as useful as a face-to-face appointment, but for some things, a face-to-face appointment would be better."

Outpatients

Measures for success

Improved patient experience.

OP **Centre of Excellence.**

Improving access for patients, face-to-face/digitally/telephone - **virtual consultations > 35%.**

Supports **regional collaboration** for best practice.

100%

Advice and Guidance – **100% response rate.**

Digital OP – **call abandon rates < 10%.**

PIFU – **2%** of all outpatient appointments to **result in PIFU.**

A reduction to< 6.5% in Did Not Attend/Was Not Brought rate.

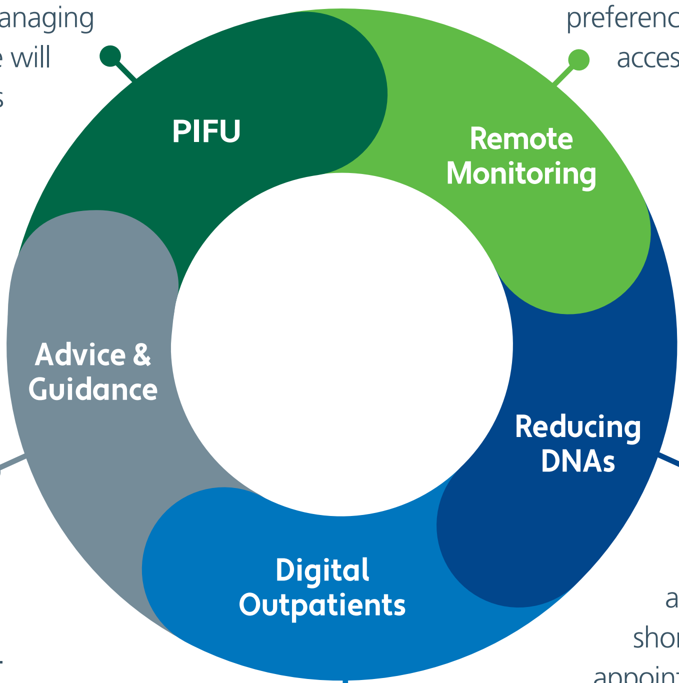
Workstreams

Patient Initiated Follow Up (PIFU)

Supporting patients with long-term conditions to take control of their own health, and access care in a way that fits their life. Encouraging our patients who meet the criteria to be actively involved in managing their own follow-up care will support better outcomes for everyone.

Remote Monitoring

Supporting outpatients to access their hospital care remotely, patients will have a choice of appointment type available to them (face-to-face, telephone or video) to ensure it fits with their individual preference and to enable equity of access to OP services.



Reducing DNAs

Work to understand the complex reasons for Did Not Attend (DNA) and Was Not Brought (WNB in Paediatrics) with the aim to reduce them and release lost appointments back into the system.

The digital system can aid DNA reduction by shortening the time between appointments being identified and being returned to services to re-book.

Advice and Guidance

Creating a point of access for GPs, for direct specialist advice and guidance to reduce unnecessary patient referrals into secondary care and better support patients in the community.

Digital Outpatients

Improving NHS digital front access, supporting modern technological platforms to maximise productivity and capacity, and provide patients with access to outpatient services in a modern way.

Patient Hub

Portal for patient correspondence, chat bot, text and e-mail.

Room Scheduling

Improve oversight of estate utilisation, number of clinics delivered and reducing geographical footprint.

RPA

Use of robots to automate and improve administration in digital systems.

Outpatients

Ambitions

Outpatient (OP) recovery means improving on our appointment offering through delivery of remote activity and productivity, doing it in a way that transforms care for patients, using the OP Transformation programme.

This will include development of the outpatient digital front-door to compliment delivery of outpatient care and will include the use of technology including digital automation of process and the use of Artificial Intelligence.

We aim to be the best practice example compared to our peers, make every patient contact a quality experience at a time and place that is relevant to their needs.

Our ambitions to achieve this over the next five years are:

YEAR 1

Standardise the outpatient offering.

Reduce Did Not Attend (DNAs).

Maximise clinic utilisation.

Improve appointment efficiency.

Improve the Patient Initiated Follow Up Offer (PIFU).

Restructure KPIs for LTHT OP.

Appoint Clinical Director for OP CSU.

Establish a Patient Hub.

Implementation of Room Booking Tool.

Develop a proposal on the long term delivery model for outpatients.

Utilise the OP Patient Level Information and Costing System analyser to monitor progress against KPIs and workstreams.

Outpatients

YEAR 2-3

OP scheduling tool routinely used to improve utilisation of the booked estate, number of clinics delivered and support reduction of OP footprint by 40% as part of Hospitals of the Future.

Resilient and future-proofed **multi-skilled workforce.**

Implementation and evaluation of a trial of **centralised OP function** for the LGI specialties.

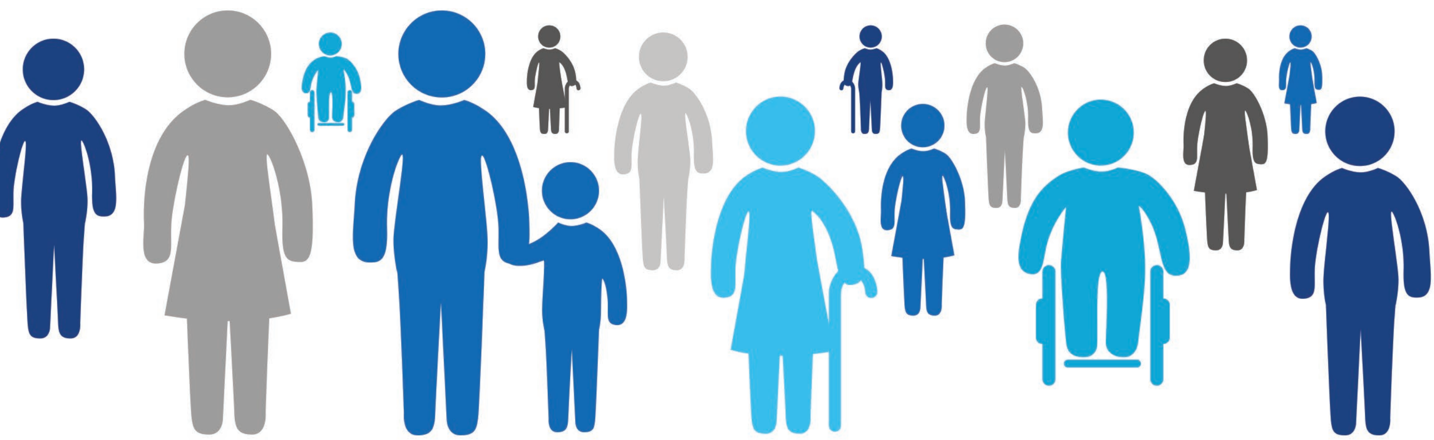
Grow our own workforce using the apprentice programme and innovative training schemes developed and supported in-house.

YEAR 3-5

Regional Centre of Excellence for Robotics Process Automisation (RPA).

Career progression programme for all OP staff, accessed via a Training Academy to support development and retention.

Deliver **a seamless OP journey** with primary, secondary and pharmacy interface.



3.3 Diagnostics

Our diagnostic services form the backbone of decision making for patient care for the patients of Leeds at primary, secondary and tertiary care levels. Diagnostic services include radiology (CT, MRI, ultrasound), endoscopy (gastroscopy, colonoscopy), pathology, and physiology services for specialties such as cardiac and respiratory.

Those providing patient care need prompt access to the most appropriate test (and report), as well as to be assured that those tests are of the highest calibre and using the latest technology to support our ambitions to deliver the best patient care.

Demand for diagnostics was outstripping capacity even before the pandemic and is predicted to continue to rise year on year. This has an impact on our ability to meet waiting time standards with a knock-on effect on care and outcomes.

Our vision for diagnostics is to have access to tests that can be performed close to home, in the community as well as central capacity for more complex testing, ensuring equity of access across the communities that we serve. By working in networks across Leeds via the Leeds Diagnostic programmes and the emerging Community Diagnostic Hub initiatives across our ICS, whilst investing in digital technology and new estates, we will be able to provide rapid test results that improve outcomes by contributing to early diagnosis and treatment.

The new purpose-built pathology building, part of the West Yorkshire and Harrogate Pathology Network, will support this transformation and support hospitals across the region to improve diagnostics for patients and help to meet the growing regional demand for specialist treatment and care - as well as providing development opportunities for staff. Offering access to world class blood pathology facilities, the new facility, which is expected to be completed in 2023, is integral in our post-Covid recovery plan to greatly improve the services we provide to our patients.

The new building will also incorporate a single, shared Laboratory Information Management System (LIMS) which will mean test requests can be ordered, tracked and results reported electronically to clinical services across West Yorkshire and Harrogate.

Our focus on getting the right diagnostic results to the right clinician at the right time, with the opportunities the new building will provide, is stimulating thinking about how to prepare for new opportunities in precision medicine, of which genetic testing will be increasingly important through the North East and Yorkshire Genomic Laboratory Hub.

5 key principles

A multi-skilled workforce with enhanced roles, skill mix at all levels and succession and growth planning.

We should only do **tests that make a difference** to clinical decision making.

Digital solutions to allow ease of working with community providers, IS and other hospitals to:

- Transfer patients.
- Share waiting lists and booking processes/ systems.
- Feed into "host" organisations EPR.

Addressing current inequities in accessing diagnostic services through community diagnostic hubs and future service locations/developments.

Testing as close to home/ locality as can be safely achieved.

- Suitable estate outside LTHT to develop community testing hubs closer to patients but in the right locations with reference to population and deprivation/equality of access needs.
- Mobile estate solutions for areas that would not warrant full time access to a facility but where access/attendance/ engagement would be much improved if the service went to them.

Diagnostics

Measures of success

≥ 6 week wait (ww)

That **less than 1%** of our patients wait more than six weeks for a routine diagnostic test.

Tests

Improve the timeliness of tests to **support emergency care and cancer pathway requirements**.

Reduction in volume of tests

Reduction in the volume of tests done on main hospital sites through innovations (Pinpoint screening for two week wait and wider genetic testing), demand management, testing closer to home and impact of community diagnostic hubs.

Workstreams

The delivery of the programme is through the following workstreams:

- Diagnostic activity and service delivery.
- Community Diagnostic Hubs for Leeds development and delivery with a focus on ensuring equity of access for our patients.
- Mobile X-ray service development to reduce unnecessary patient conveyance to LTHT, initially focussing on frail, elderly care home residents.
- Demand management/responsible requesting focussing on the rise in acute requesting/what difference the test requested will make to patient care.
- Introduction of text reminder service to diagnostic pathways (following OP model) to reduce DNA and late cancellation rates.
- Endoscopy city wide plan for future - supporting doing only what needs to be done in hospital and ensuring the right capacity is in place to inform BTLW provision.
- Health and Wellbeing measures development, recognising the key constraints, including chronic national shortages in some areas, and the options to address in our diagnostic workforce.

Ambitions

Our five year Transformation programme to deliver high quality diagnostics services for our patients.

YEAR 1

Delivery of 6ww recovery.

National D coding (the mechanism by which we classify clinical priority order in the diagnostic waiting list and helps in planning capacity) completed.

Planning for Community Diagnostics to support patient prioritisation - mobile and hub/UTC extension/city wide provision.

Implement principles for responsible requesting/best in class utilisation.

Develop future workforce models.

Open the new Pathology Building.

Launch the new single, shared Pathology Laboratory Information Management System (LIMS).

YEAR 3

Community Diagnostics - mobile and hub/UTC extension pilots completed and next stage in progress.

City wide provision for Endoscopy agreed and model implemented.

Impact of responsible requesting/ best in class utilisation being seen.

Implement future workforce strategies.

Enhance the use of pathway genetic testing.

YEAR 5

Only patients needing specialist or IP testing undertaken at LTHT main sites.

Achieving best in class for utilisation for significant number of specialties.

Robust long term city wide workforce plans in place.

3.4 Planned Care

The Covid pandemic has increased the length of time patients at LTHT are waiting to receive elective surgery, ie operations planned in advance. We have a proud record of delivering high quality care with excellent outcomes for our patients. However the timeliness of this care, for those having a planned procedure has not matched these high standards and people have waited too long.

As with many NHS organisations the numbers of patients waiting over 104 weeks for planned care has grown. We will address this backlog in the first year and reduce to 78 weeks the maximum wait time, with the aim being over subsequent years to reduce this to a maximum wait of 52 weeks with the vast majority of patients being treated within 18 weeks of referral.

5 key principles

The best patient

Patients will be medically optimised, through robust pre-assessment that involves patients in the decision-making about their care and provides pre-surgical interventions, resources and access to services that ensures patients are in the best physical and mental condition to continue with their treatment.

This reduces the risk of harm during and following surgery, as well as reducing the amount of time they need to stay in hospital following a procedure.

We will support primary care colleagues to ensure they are informed and empowered to discuss appropriateness of care with patients at point of decision to refer. We will use health data systematically and proactively, identify patients who have or are less able to access healthcare - reducing the health inequalities for the citizens of Leeds and the surrounding area.

The best pathway

Day Case as default will be the mantra for our elective services, ensuring that patients spend as little time as possible in hospital, and only when clinically justified.

We will develop alternatives to overnight stay for social reasons with primary and social care partners.

Elective theatre lists will be scheduled appropriately using scheduling tools and matching expected length of stay to expected capacity, reducing the risk of patient cancellations. We will continue the development of enhanced care areas, reducing the demand for critical care capacity, and ensuring that those patients who do need critical care are able to access it without delay.

Using the Leeds Improvement Method, quality improvement projects will be agreed and sponsored to focus on the efficiency of the entire pathway, removing waste and ensuring the maximum opportunity to treat patients is taken.

Planned Care

The best team

Our services rely on our staff, and as well as expanding the workforce we need to retain and develop it with new skills and roles across the entire pathway, ensuring our staff only do the work they need to do at the most appropriate time.

We will grow our workforce through both local and international recruitment, and will work closely with our local education providers to develop innovative training schemes that support a sustainable workforce, both now, and in the future.

The best place

Our teams will also cross organisational boundaries in the future as we collaborate more closely with WYAAT colleagues to develop shared pathways and workforce to treat our patients as close to home as possible.

Hub and spoke models will allow the sharing of workforce and agreed governance models to improve the patient pathway.

Collaboration with WYAAT will allow us to deliver elective care jointly where appropriate, utilising or developing current estate more effectively to create efficient elective hubs for the region and strengthening partnerships with other Trusts.

The right time

We will ensure that all patients who require acute or urgent access to treatment continue to receive their care as required. However we will also focus on delivering timely care for our non-urgent patients.

Our patients deserve to be treated within the timescales set out in the NHS constitutional standards wherever they live in the region. We will work with our WYAAT colleagues to offer and receive support for those specialties that are unable to meet the constitutional standards, ensuring equity of access for all patients.

We will also work specifically with those specialties that are unable to deliver timely care to understand their barriers and develop comprehensive actions to reduce the number of patients waiting unacceptable lengths of time for treatment.

Measures of success

85% utilisation

Increase theatre productivity to achieve 85% utilisation by March 2026.

Three day length of stay

Reduce average length of stay to three days for all elective surgical admissions by March 2026 (excluding day case).

85% conversion rates

Increase rates of conversion from inpatient to day case procedure to 85% by March 2026.
(Of procedures recommended by British Association of Day Surgery to be performed as a day case).

Workstreams

The Planned Care Programme of work incorporates and supports specific workstreams that have been identified as key to LTHT's elective recovery for adult and paediatric services.

We know that waiting a long time for a procedure can have a detrimental impact on outcomes for individual patients, By creating additional capacity we intend to reduce waiting times and improve outcomes for patients.

The delivery of the programme is through the following workstreams with designated managerial and clinical leads for each stream:

- BADS (British Association of Day Surgery) day case.
- Pre-optimisation.
- Theatre efficiency and productivity.
- Elective care hubs.
- Enhanced care.

Whilst increasing elective capacity is key to any recovery, how we use that capacity is even more important, and the programme focuses on lessons learned from our Covid response in terms of new ways of working and standardised work to set challenging goals for our services. The programme has also focussed on our experience of consistently delivering our elective programme over the entire year, taking into account seasonal pressures. To help define our ambitions, the programme has benchmarked our expectations and KPIs against what our peers are delivering, and best practice examples and collaboration with other Trusts has helped form our programme scope.

Planned Care

Programme focus - Elective care hubs

Extra Capacity

Chapel Allerton:

- Two new theatres.
- Specialist enhanced care facility.

Wharfedale Hospital:

- Two new theatres (one HDHT).
- Overnight stays.

LGI & SJUH:

- Protected elective capacity at SJUH and LGI.

Up to 10 extra spinal patients per week.

Up to 55 extra elective care patients treated per week.

Focus on >104 weeks with changes to theatre utilisation.

Reduction in cancellations across all sites with increasing certainty of available capacity.

Additional jobs for local community.

Supporting regional collaboration through sharing of resources including physical capacity and promoting a flexible workforce able to respond to changing needs of the service.

Improved patient experience.

Protected '**centres of excellence**'.

Supporting further **regional integration.**

Improved environment for patients.

Improving working lives for staff.

Increase efficiency - reduce use of Independent Sector over time

Ambitions

This programme is dedicated to delivering levels of high quality activity above and beyond that previously seen and to ensure we are in the top quartile of delivery against our peers for our key programme indicators.

Our ambitions for the Planned Care Programme over the next five years are:

YEAR 1-2

Return to 104% of pre-covid productivity.

Eliminate all 104 week waits and reduce maximum wait time to 78 weeks.

Wharfedale Hospital and Chapel Allerton Orthopaedic Centre elective hubs developed.

Development of protected elective capacity on both the SJUH and LGI sites.

YEAR 3

Health inequalities data used to support service development and priorities.

Recovered all waiting lists to pre-Covid levels.

YEAR 5

WYAAT collaborations/ regional elective pathways as business as usual.

Dedicated day case facilities at SJUH.

3.5 Cancer

LTHT offers one of the largest and most comprehensive cancer centres in the UK, with state-of-the-art diagnostic services in both radiology and pathology.

Our clinical work is underpinned by internationally acclaimed research and innovation which is supported by our partnership with the University of Leeds and facilities funded by the National Institute of Health Research and organisations such as Leeds Hospitals Charity, Yorkshire Cancer Research, Cancer Research UK and other charities.

Leeds Cancer Centre is an integrated cross-city cancer care delivery organisation connected to the people of Leeds, wider Yorkshire and beyond. It represents the combined focus of Leeds Teaching Hospitals staff in realising the best cancer outcomes for the patients in their care. In addition to adult and children's services we provide specialist facilities for teenagers and young adults.

Whilst cancer prevalence is increasing so are survival rates. We will work with city partners to support the city-wide ambition to improve one and five year year survival and reduce the incidence of cancer diagnoses via emergency presentation. We will continue to support the improved recording of staging data.

The pandemic has had an impact on our diagnostic pathways and cancer care delivery services and we have had to adapt. The way we have responded to the pandemic has brought about changes to care delivery which has in many cases improved patients' experiences of their care. We will develop our diagnostic capacity to deliver the new Faster Diagnostic Standard (FDS) to diagnose or rule out cancer within 28 days of referral. We will investigate and implement new and innovative ways of working and delivering care, emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care, making sure that no person living with cancer is left behind and that health inequalities narrow rather than widen.

This work will be overseen by the newly re-established LTHT Cancer Board chaired by an Executive.

> *"I have had five days of radiotherapy and have been made to feel relaxed and things have been explained all the way. Everyone is lovely and friendly which is what you need when you are most vulnerable. You made it as nice as it could be, thank you."*

Cancer

In 2021 we:

saw over
38,000
2ww patients

saw over
1600 **breast symptomatic** patients

collected
28 day FDS data
on over **40,000 records**

delivered
6361 separate **first definitive** treatments

and
12,293 separate **subsequent** treatments

4 key principles

Patient care

- Equity of access should be at the heart of the services we deliver/redesign.
- Focus on areas where our cancer survival is not optimal as a priority.
- Person-centred care will be at the heart of everything we do.

Digital

- Transfer of patients, shared waiting lists and booking processes/systems across WYAAT/ICS/Leeds. Key data needs to be viewable at patient contact points across all care settings.
- Successfully implementing new technologies/screening tests starting with artificial intelligence (AI) and robot workers (MDT coordinator basic tasks).
- Appropriate and easy technologies to support remote/patient initiated follow-up, including tele-monitoring/ patients data input.
- Remote access for patients to holistic needs assessments and personalised care and support plans.

Workforce

- We need to grow our work-force to support new ways of working and new services whilst we pilot, succeed and then move to new models without destabilising existing provision.
- We need to innovate with new roles to address significant workforce constraints across the ICS, regionally and nationally in areas such as non-surgical oncology, radiology, pathology and breast cancer services.
- We need to use the Leeds reputation to support areas that can't recruit across WYAAT/ the ICS so that we achieve our aim to maintain local district general hospital services alongside our tertiary and specialist services requirements.

Estate

Ensuring expansion of services is in the right place and only centralised on main site LTHT when required. Current areas of focus are Breast, Genomics and cold site operating for key surgical specialties.

Cancer

Measures for success

Post Day 62 backlog
to be at **pre-pandemic level by March 2023.**

Improving timeliness of care
measured by **consistent delivery of the Cancer Wait Times (CWT) constitutional standards** including new 28 FDS standard.

Increase in patients
who have an **initial frailty/holistic assessment at the start** of their cancer pathway.

Optimal pathways
with **measureable milestones** in place **across all cancer pathways.**

Increase in patients
who have **filter tests/triage prior to a 2ww referral/being seen** at LTHT.

MDT (multi-disciplinary team) staff in post increased
and staff survey health and wellbeing score improved.

Increase in patients
who are moved to **Patient Supported** or **Patient Initiated Follow-up pathways.**

Quality programme

- **National Patient Experience Survey -** ambition to be the best amongst our peers
- **MDTs are as streamlined as possible** and are meeting National Peer Review indicators
- **Personalised care is embedded into all our pathways** in the form of Shared Decision Making and access to personalised care and support plans

Workstreams

The delivery of the programme is through the following workstreams:

Cancer activity and delivery of timely services

with an early focus on 62 day backlog reduction to pre-pandemic levels alongside achievement of the new 28 day faster diagnostic standard.

Delivery of revised optimal pathways

including development of new pathway specific milestones (testing in line with optimal pathways development).

Expansion of frailty and one stop assessment (rapid diagnostics)

to all pathways beyond vague symptoms and breast, with lower and upper gastrointestinal the first area of focus.

Person Centred Care

continue the roll out of access to personalised care and support plans and embed Shared Decision Making throughout all cancer pathways.

Staff health and wellbeing

with MDT coordinator workforce to ensure we have the right future fit and role reward in place.

Enabling innovations to support more streamlined patient care

- two week wait (2ww) pre-referral filter blood tests to better target patients (and reduce referrals).
- use of oral lesion photography triage building on dermatology pathway work.
- capsule endoscopy pilot evaluation.
- slicker genetic testing using new small panel equipment and pathology automation to reduce result turnaround time for samples (TAT).
- use of Artificial Intelligence/robotic workers to support routine MDT coordination/ patient tracking task.
- expansion of key services to support better patient treatments in radiotherapy and robotic cancer surgery.

"No-one wants to deliver bad news, but it's so important it is delivered in a sensitive way. If you've built a rapport, even if it's for a couple of minutes, you are making the journey easier for both the clinician and patient."

Cancer

Ambitions

Leeds Cancer Centre will provide the best patient centered cancer care in a seamless and integrated way that is best for patient safety, quality and experience. It will do this in an environment that is the best place for staff to work and feel empowered and accountable. It will deliver excellent research and innovation, education and specialist services.

YEAR 1

Testing innovations creating test bundles.

More widespread frailty assessments.

Planning for expanded services (breast, pathology, genetics).

Pathology and Radiology KPIs developed.

Reduce 62 day backlog to pre-pandemic levels.

Robotic surgery replacement and expansion.

Continue to roll out Cancer MDT streamlining.

Establish work programme focussed on reducing for health inequalities.

Increase number of PCSPs.

YEAR 2-3

Introduction of Head and Neck and Gynaecology optimal pathways.

Radiotherapy linear accelerator capacity expansion.

Shared decision making embedded through all pathways.

YEAR 3-5

Filter tests in place reducing need to attend main sites.

Breast symptom and screening service combined.

Generic testing and personalised treatments wider development.

3.6 Unplanned Care

When people need emergency or unplanned hospital care, they want prompt, safe and effective treatment that alleviates their symptoms and treats the underlying causes of their illness. They want care that is aimed at getting them better as quickly as possible.

We know that any prolonged stay in hospital, or large numbers of patient moves whilst they are in hospital, contributes to poor outcomes, poor patient experience and increases the risk of falls, pressures ulcers etc. In response to this 'deconditioning' the Trust will establish a multi-disciplinary group to support changes and address the underlying issues. A key measure of success therefore will be to reduce the length of stay and reduce multiple moves of patients to only those that are clinically necessary.

Emergency and unplanned care has responded rapidly to waves of Covid and the impact it has had on people and service availability. This impact has been felt across the whole Leeds healthcare system including the availability of on-going care for people who no longer have a reason to reside in a hospital setting.

Bed occupancy in our hospitals remains at some of the highest levels within the NHS, with patients waiting far longer than we would wish in our emergency departments. Our evolving knowledge of Covid brought with it rapid requirements to change how we delivered emergency and inpatient care. Combining this learning from the pandemic together with the changing needs of other emergency patients has given us a powerful opportunity to evolve and transform care.

"Amazing four hours from check in to leaving, fast and efficient with first set of observations, then I was put into a side bay due to positive corona (had it six weeks ago so not contagious just still testing positive). A lovely gent did my second lot of observations and brought me a hot drink and sandwich. All the staff were polite who dealt with me and the doctor was fast and efficient. My only wait was for blood results. Fab service."

5 key principles

7-day clinical review

We are committed to enhancing our weekend cover for our inpatients and to increasing the number of senior clinicians available over weekends to see our patients.

General internal medicine

We will increase the number of doctors caring for inpatients with a general medical condition.

This will be achieved through recruiting to new, innovative roles and including more specialists in ward care.

Home First - reducing length of stay

The expectation is that most patients will return to their own home, either with support or without. This is the right thing for most patients.

Workforce

We will expand our workforce responsible for supporting patients being discharged to ensure everyone leaving our hospital does so in a timely and informed way.

This will include additional cover to assist patients who require support services when they are discharged home, to a temporary community bed or to a permanent care facility for ongoing rest, recuperation and rehabilitation. We will provide discharge support to the clinical teams over seven days.

Achieving service delivery standards

Eliminate number of patients in Emergency Departments for more than 12 hours from arrival to leaving.

Consistently be in the upper quartile for delivery of the Emergency Care Standard. (Currently delivering 68% against a 95% standard. Best in class is 90%.)

Consistently be in the upper centile for timeliness of ambulance handover.

Less than an hour for all ambulance handovers.

Consistently be in the upper quartile when compared with peers of delivery by reducing the proportion of inpatients with a long length of in-patient stay (over 21 days).

Reduce number of times a patient moves for non-clinical reasons.

Virtual ward delivering capacity and access of **40–50 virtual ward beds per 100,000** population.

Reduce average length of inpatient stay by one day.

Reduce number of patients who have been assessed as no reason to reside in an acute hospital bed.

Increase number of patients who are discharged directly home from hospital.

Improve the NHS in-patient survey score pertaining to leaving hospital from 6.9 to 8.0 to align with the top peer performing acute Trusts.

“My care felt joined up - I’ve come back home with a package of care and am delighted.”

Unplanned Care

Workstreams

Through the systematic implementation of known good practice underpinned with the Leeds Improvement Method we will deliver:

A new front door to the hospital emergency care pathway

This will include **Urgent Treatment Centres** (UTC) that are co-located with the emergency departments, providing an opportunity to stream patients with less serious illnesses and injuries to a service that is resourced to meet their needs, while reducing crowding in our emergency departments.

A city **Primary Care Access Line** (PCAL) will take phone calls (within a minute) from Yorkshire Ambulance Service, GPs and other clinical city partners. PCAL will access the right clinical service the patient needs through hot clinics, assessments areas, advice and guidance, admission or emergency department attendance.

There will be a comprehensive **Same Day Emergency Care** (SDEC) service which will offer an alternative to the emergency departments with direct access from NHS 111 and ambulance service for patients.

A city wide multi-specialty virtual ward

Virtual wards are a system-wide supported service model to support patients, (who would otherwise be in hospital) to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence. This will meet the needs of patients that require clinical input and review without the need to be admitted to hospital.

A reduction in delays for inpatients and ensure timely care and discharge

All patients requiring community support or an on-going place of care will have a **referral completed describing their needs**. Referral will be submitted to the transfer of care hub in a timely way.

All patients who require support on discharge are **identified at the earliest opportunity** following admission.

Our teams will work with the transfer of care hub to ensure the patient is on the optimum discharge pathways and **no patient stays in hospital longer than they need to**.

We will **continually learn** from the clinically led Multi Agency Discharge Events (MADE). Using a quality improvement approach, the programme aims to engage teams using a bottom up, patient centred approach to reducing delays for our patients.

We will ensure that patients and their families are provided with written information about their discharge plan and the community services available. **Patients and families will always know and agree with their discharge plan**.

We will systematically **review all patients who have a long length of stay in hospital** to support the next steps for that patient.

We will work with system partners to promote **a "home first" approach**.

We will work collaboratively to **turn the tide on the deconditioning of patients** whilst in our care.

On the day we will ensure the **discharge is safe and timely**.

We **will not move patients from one ward to another unless it adds value to that patient**. We will achieve this by redesigning the operational model.

Unplanned Care

Ambitions

Our ambition is for acute unplanned care to be delivered across all care settings (essentially a hospital without walls). To support the work of the Clinical Service Units (CSUs) we will increase the capability of the Ops centre and develop a live bed state to support operational flow.

We want to maintain patients in their own homes where and whenever possible, supported by an integrated system approach across the city that considers hospital admission/intervention to be limited to an urgent clinical response for a prescribed time.

This will be underpinned with the need to reduce heath inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way.

YEAR 1-2

Eliminate waiting by patients in Emergency Department from arrival to 12 hours still in the department (reduce from 40 patients per day to 0).

Return to pre-pandemic delivery of the Emergency Care Standard.

Eliminate or better all ambulance handover delays of longer than one hour.

Reduce number of patients admitted to hospital beds by a further 10% by increasing the use of the SDECs and delivering care closer to home.

Develop the patient placement model, informed by real time bed state to ensure patients are admitted to the right place first time, and only moved from there if clinically appropriate.

In partnership with city partners support a sustained community provision offer to enable those who can return home to do so, with support and to place appropriately and quickly those patients who need intermediate or long term residential/ nursing home care.

100% of patients will receive written discharge information on admission.

40% of patients will be discharged before 3pm.

80% of patients will have an agreed expected date of discharge set within 24 hours of admission and a criteria led discharge plan if appropriate.

All patients requiring support on discharge will have a referral submitted to the transfer of care hub within 12 hours of a ‘no reason to reside’ decision.

YEAR 3-4

Where possible we will look for integration of the SDEC models across areas such as:

- Mixed Specialty Assessment Area (LGI)
- Emergency General Surgery (Ambulatory)
- JONA (Oncology Assessment)
- GATU (Gynaecology Assessment)

with the intention of strengthening ambulatory flows and reduce demand for inpatient beds.

An Urgent Treatment Centre at the front door of St. James's Emergency Department for patients who self-present.

A designated medical SDEC unit built to increase capacity to deliver alternatives to admission and rapid senior decision making where 80% of patients who need an inpatient bed will be assessed by the specialist and given a treatment plan at home or in hospital depending on their care needs and wishes.

Virtual ward delivering capacity and access of 40–50 virtual ward beds per 100,000 population.

Reduce average length of stay by a further one day.

Reduce by 50% the number of patients with no reason to reside.

YEAR 5

Eliminate all ambulance handover delays of longer than 15 minutes to support the ambulance being able to respond to the next 999 call.

An Urgent Treatment Centre at the front door of Leeds General Infirmary Emergency Department for patients who self-present there.

A designated Multi Specialty SDEC unit built to increase the capacity to deliver alternatives to admission and rapid senior decision making where a patient will be assessed by the specialist and given a treatment plan at home or in hospital depending on their care needs and wishes.

Recruit two more Consultants to General Internal Medicine to complete a Consultant led ward round on every medical ward every day.

Patients will be discharged home or transferred to another place of care within 48 hours of a decision that they have no reason to reside in an acute hospital bed.

LTHT will be a top performing Trust in the inpatient national survey for hospital discharge.

The Leeds Teaching Hospitals NHS Trust
2022

Designed by Medical Illustration Services, LTHT 20211130_007/NR