Report to:	Board of Directors				
Date of Meeting:	31 January 2018				
Report Title:	Right Care				
Status:	**For information**	**Discussion**	**Assurance**	**Approval**	**Regulatory requirement**
Mark relevant box with X	X				
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Executive Sponsor (presenting):	Bridget Fletcher, Chief Executive				
Appendices (list if applicable):					

Purpose of the Report

This update report outlines the progress and performance of the Right Care Portfolio of Programmes at Quarter 3 (October-December) 2017 with a focus on plan delivery.

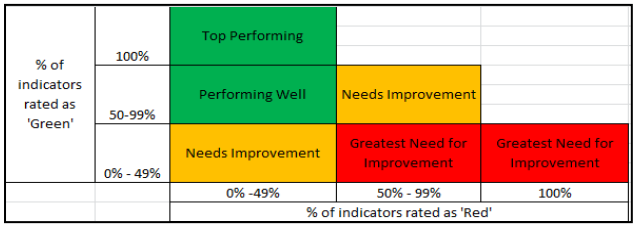
Key points for discussion

The Board of Directors should note that:
The Right Care portfolio now consists of four programmes:

- People Plan: Projects progressing well. The focus will now be on defining new programme work streams to enable delivery of the workforce strategy.
- Flow: Positive engagement on SAFER; Acute Assessment Build on track; new working models for Acute Assessment Unit progressing well.
- Value: Clinical engagement is positive; the focus remains on implementing plan to reduce delays, enable clinical prioritisation, and no unnecessary operations after midnight, and developing benefits plan to measure this.
- Integrated Health Record: Benefits planning and measurement progressing well, functionality being delivered in current projects. Digital strategy day planned for 2nd February.

Portfolio Level

- All programmes will continue to develop benefits realisation plans which will link to the Trust's Cost Improvement Plan.
- Standard approach to RAG rating implemented based on expected delivery of each Project within the programme vs. planned delivery date agreed in Programme Plan:
- Green is within 1 month, Amber between 1 - 3 months, Red is more than 3 months.
- Indicators are currently defined as project delivery against timescales
- The Project status' are then aggregated to provide an overall RAG of the programme as below:



Recommendation

The Board of Directors is asked to receive and note the performance of the Right Care Portfolio of Programmes.

1.0 Executive Summary of Portfolio Progress

- Delivery across all programmes is positive and on track.
- See programme updates for further detail on progress.

1.1 Portfolio Status Overview

Ref	Page	Programme:	Plan Delivery
2.1	3	People Plan	
2.2	6	Improving Patient Flow & Transformation	
2.3	9	Value Programme	
2.4	11	Integrated Health Record	

2.1 People Plan

Aims of programme

- Improved staff satisfaction ratings and reduced reported staffing pressures.
- Improved engagement and productivity.

Progress in period

Well-Led

Embed values and behaviours

- Embedded in Personal Development Reviews (PDR); 83% completion rate.
- PDR process continues to be actively promoted through corporate induction and leadership programmes.

Recruitment of senior leaders

- Deputy medical directors commence in roles on 1 February 2018

Right Care Senior leaders

- Cohort 1 underway and finishes Jan 19.
- Cohort 2 commenced September 2017and includes Clinical Directors, Matrons and Patient Services Managers.
- Cohort 3 planned for April 2018.
- Strategy event delivered to all three cohorts December 2017.

Photos show strategy event presentations:

Coaching and mentoring

- 29 trained mentors (half day training), 27 cross professional mentor pairs.
- 10 trained coaches (3 day ILM 5).

Healthy and Engaged

Pulse Surveys

- Extended to provide group level results.
- The annual staff survey opened in September and ran through to December 2017. Early indicative results will available January 2018 but embargoed until February 2018.

Well Being Offer

- Airefit continues to offer exercise classes and following successful marketing through December class numbers have increased.

Freedom to Speak Up

- Staff are making use of this service. The number of concerns has now levelled..

Resilience and Stress Management

- The day 1 referral service for staff with stress related absences was introduced in September and continues to generate timely referrals to EH&WB.
- The site based Remploy Vocational Rehabilitation Consultant partnership is continuing and additional sessions are planned to meet the increase in referrals.
- Sickness and stress related absence decreased in December to 59 cases from 67 in November 2017.

Productive

HR Case Manager

- Case manager commenced July 2017. This appointment continues to have a positive impact with managers. Engagement with groups and employee health remains a priority to reduce sickness absence. The sickness absence policy is being revised to incorporate best practice and guidance for managers and staff.

Job Planning

- New framework in place and communicated. The deadline for job plan completion was extended to 1st January 2018.

Skilled and talented

Nurse recruitment

- Nurse recruitment event held 7th November and this proved to be very successful with 36 offers being made on the evening.
- A further recruitment event is scheduled for 10th February with an active marketing campaign in place to promote the event.

Development of new roles

- Nurse Associates and Student Physician Associates deployed. Work underway on defining other new roles.

Apprenticeship Programme

- Third Cohort of Healthcare Support Worker (HCSW) Apprentices recruited. Plan to extend to other roles under development.

Education and Training Offer for Bands 1- 4

- Development work has started with further dates planned for January 2018 to take this forward.

Plan for next period

Well-Led

- Launch Values Based Recruitment Toolkit and training for managers.
- Continue delivery of Right Care Senior Leaders (RCSL).

Healthy and Engaged

- Provide further support on resilience and stress management, promotion of the Day 1 service in partnership with Trade Unions – union sponsored events.

Productive

- Review sickness absence policy with unions.
- Complete job planning or mediation for consultants and SAS doctors.
- Develop implementation plan to support delivery of the Workforce Strategy.

Skilled and Talented

- Develop proposals for enhancing talent management across the Trust.
- Finalise the Band 1-4 Development Offer.

2.2 Improving Patient Flow and Transformation

Aims of programme

- Improved access to emergency and urgent care by improving the processes associated with streaming, ambulatory care, environment and the flow within the Emergency Department, Acute Medical Unit and the adult wards.
- Improved discharge processes ensuring patients do not experience unnecessary waits.
- Engaged and supported workforce, maximising skill, sharing expertise and efficiently delivered.
- Provide value for money services, simplified, standardised and shared.

Progress in period

Complex Care Model

- Projected throughput for the year is 200. This is 35% of the 563 which was planned in the original business case. Although this is lower than planned, it is felt we are exceeding the planned 25% reduction in spend per person. However, this cannot be confirmed as we only have access to data from 2 of the 10 cost categories which the payback analysis was based on (19% reduction in Emergency Department attendances and a 39% reduction in non-elective admissions).
- Average referral rates per month have doubled. From an average of 12.6 in the period of April – August to 24 in November.
- 290% increase in new people accessing complex care. 23 new people accessed complex care in November after average of 8 per month in Q1 & 2.
- 89% people achieving personal and social goals.

Patient Flow (SAFER)

- Positive engagement with senior nursing colleagues (Director of Nursing, matrons and ward sisters) at SAFER steering group and SAFER Operational Group meetings.
- Ongoing metrics to assess gaps in standards. As yet, not having systemic impact. However, when December–January 16/17 to December–January 17/18 are compared there are some high level metrics that suggest systemic improvements – mainly a reduction in patients with a Length of Stay (LoS) over 14 days; reduction in LoS, reduction in Delayed Transfers of Care (DToC) and reduction in breaches due to patients waiting for a bed as well as an improvement in the emergency care standard.

Ward	Number of Discharges		November 17 Discharge split by day							Average LoS		% patients D/C before 1pm		% patients who were transferred from AMU between 6am & 10am		No. patients on ward with LoS 14-27 days		No. patients on ward with LoS >28 days	
	Nov-17	Prev 6 month average	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Nov-17	Prev 6 month average	Nov-17	Prev 6 month average	Nov-17	Prev 6 month average	Nov-17	Prev 6 month average	Nov-17	Prev 6 month average
Ward 1	60	58	14	17	11	5	11	1	1	5.63	4.26	23.33%	17.24%	8.57%	6.67%	1	0.0	0	0.0
Ward 2	355	402	49	52	53	63	43	49	46	1.33	1.33	14.08%	14.43%			0	0.0	0	0.0
Ward 4	56	71.3	5	6	16	14	13	1	1	16.16	14.49	48.21%	29.87%	3.33%	5.74%	10	6.0	3	2.3
Ward 5	39	34.6	5	9	11	8	6	0	0	16.77	25.38	28.21%	28.90%	26.32%	7.19%	2	5.5	12	9.7
Ward 6	81	73	14	13	21	15	12	5	1	14.84	13.21	30.86%	23.97%	3.90%	3.98%	2	7.2	0	3.7
Ward 7	107	115	17	17	21	20	19	9	4	8.66	8.77	15.89%	16.61%	1.15%	3.52%	3	4.0	2	2.5
Ward 10	61	44.6	4	11	9	12	18	6	1	19.66	29.04	29.51%	24.22%	0.00%	2.89%	14	9.3	12	9.8
Ward 9	97	81.8	13	11	16	29	16	7	5	7.16	8.39	26.80%	19.68%			3	3.8	2	4.2
Ward 18	138	138	24	22	25	19	30	11	7	4.71	4.92	23.19%	18.70%			0	1.0	0	0.8
Total	934	960.3	131	141	172	180	157	88	65	7.18	7.37	22.06%	18.60%	4.00%	4.43%	34	37	31	33

What the metrics are telling us:

- Discharges on Saturday, Sunday and Monday are the lowest across the week leading to problems with flow on these days (increased bed occupancy, increased outliers and failure of Emergency Care Standard).
- Average Length of Stay continues to reduce.
- Although significant improvements have been made in % patients who are discharged before 1pm (from 17% in August to 22% in November), further work is needed to reach target of 33%.

- Number of long stay patients has decreased slightly, but further Multi-Disciplinary Team work required.

Acute Care Unit Build

- Build on track for a forecasted handover date of 02/05/18, however there is potential for this to be brought forward; this will be confirmed in mid-February.
- No specific challenges to report.



Acute Assessment Unit

- Continued to hold Rapid Improvement Events in November and December. Live streaming led to approximately 20% of admissions going straight to Ambulatory Care Unit (mirroring desktop predictions). Further testing is required to establish definitive model.
- Primary Care streaming is directing 21% of patients who attend the Emergency Department (during the hours of operation) to primary care service.
- 7 day 12 hour Ambulatory Care Unit (ACU) service in operation including Saturday/Sunday service. Excellent progress driven, clinically led and management supported.
- Increased ACU prospective patient cohort by moving away from pathway led acceptance criteria to a GAPS based policy (Glasgow Admissions Prediction Score).
- Throughout a 7 day period, 23% of medical admissions are through ACU, this increases to 33% if we look at weekdays only. The increase during weekdays is due to the presence of Acute Physicians, who carry expertise in this area.
- Administrative review of Emergency Department and Acute Medical Unit processes is ongoing.
- Alignment of site/bed management - finance agreements have been completed to enable the Telemedicine role to be transferred form the Site Managers to the Hub from April 2018.

Plan for next period

Complex Care

- Ongoing recruitment to vacant posts.
- Review of non-elective admissions to identify people who would benefit from complex care to increase number accessing the service.
- Increase numbers on caseload – estimated capacity when fully staffed 180.
- Reduce average length of stay in complex care to 4 months.
- Work with CCG, BDCFT and YorDales to identify impact of complex care on GP practices, ambulance trusts, mental health services and prescribing costs.

Patient Flow (SAFER)

- 'SAFER Whiteboards' will be rolled out across all base wards, after the successful trial on Ward 7, where the Ward Sister and Consultant felt it made a significant impact on SAFER metrics.
- Undertake a systematic review of all tools recommended by ECIST (Emergency Care Intensive

Support Team) and implement any relevant guidance.
- A conference call will be arranged in January with all WYAAT SAFER leads to share learning.
- Criteria led discharge is currently going through governance processes, with the aim of being embedded with ward teams in the first week of February.

Acute Assessment Unit

- Continue to run Rapid Improvement Events to establish definitive streaming model.
- Working with Surgical colleagues to scope out and prioritise surgical pathways for Ambulatory Care in the new unit.
- Clinical Directors and GPs at YorDales have agreed new guidance to promote the efficiency and effectiveness of GPs in Primary Care Streaming. We will continue to measure and report formally on the % of patients seen each day.
- Test and measure Initial Assessment Team at front end of hospital. Agree standard operating procedure with the respective clinical directors, identify hours of operation and staffing arrangements.

Next Steps

- Review current work streams and where appropriate move into business as usual.
- Agree scope of work for 2018/19, which will likely include; embedding new ways of working in the new unit and developing a Care Coordination Centre with the provider alliance.

2.3 Value Programme

Aims of programme

- To develop a patient centric/quality and safety efficiency improvement focused programme.
- To eliminate avoidable harm and remove waste.
- To develop culture that engenders teamwork and transparency.
- The programme is a key component in the delivery of the Right Care Strategy and Trust objectives in relation to patient experience, care and service transformation.
- To provide assurance to the Board about patients receiving their treatment in a compassionate, efficient and timely way in a safe working environment with the right roles, people and ways of working.

Progress in period

Acute Surgery

- Project Lead and Clinical Lead have been formally agreed.
- Pathway mapping has been completed.
- Audits were undertaken in November 2017:
    - Reason for delays. The mains reasons are:
        - Ward delays - Patient not ready and Theatre checklist not filled in
        - Theatre delays - Surgeon not available and 'Other'
    - Patients treated after midnight and clinical reason. 3 operations from April 2017-October 2017.
    - First patient on every list:
        - 22 lists were audited on the first patient of every list. 5 out of 6 (83%) acute, 2 out of 3 (67%) trauma and 4 out of 9 (31%) electives did not start on time. Overall 50% of lists did not start on time. The main reasons were surgeons and anaesthetists on a ward round.
    - Transferring a patient SOP has been approved.
- Transfer of patients competency training is being carried out in theatres and will be rolled out to wards.
- Project team (Band 6 Acute Leads, Clinical Lead and project manager) meet regularly to review implementation of ideas and plan further tests.
- Theatre staff (clinical and non-clinical) project engagement continues.

Pre Op Assessment

- Online pre-op tools explored and a decision has been made to use Synoptsis. A business case has been put together.

Plan for next period

Acute Surgery

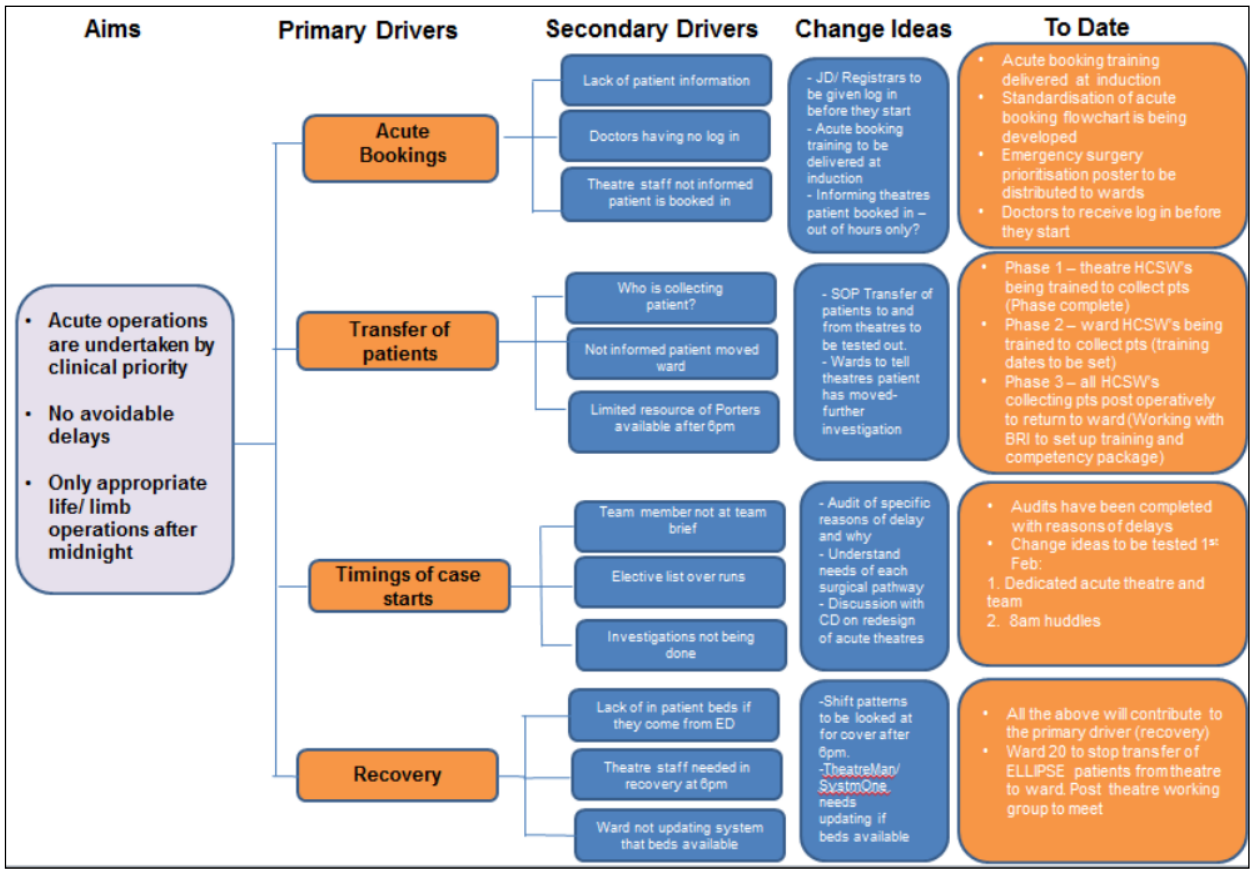
- Continued engagement with theatre staff and Value Programme Board.
- Pre-op and post-theatre project teams to work on reducing did not attends (DNAs) and transfer of ELLIPSE patients from theatre to ward.
- Testing out the two change ideas from 1st February 2018:
    - Dedicated theatre and acute team

- 8am huddles

- SOP transfer of patients to and from theatres training to be rolled out to all theatre and ward staff from February 2018. Also discussions are taking place with Bradford Teaching Hospitals to develop a training package.
- Design 'ideal state' process map.

Pre Op Assessment

- Dates to be agreed for trial period of Synoptsis subject to business case approval.



2.4 Integrated Health Record Programme

Aims of programme

- To realise the strategic aim of a paperlite organisation for clinical services through the use of an Digital integrated health record
- Increased system functionality and improved productivity via real time capability
- Reduced variation of systems and processes

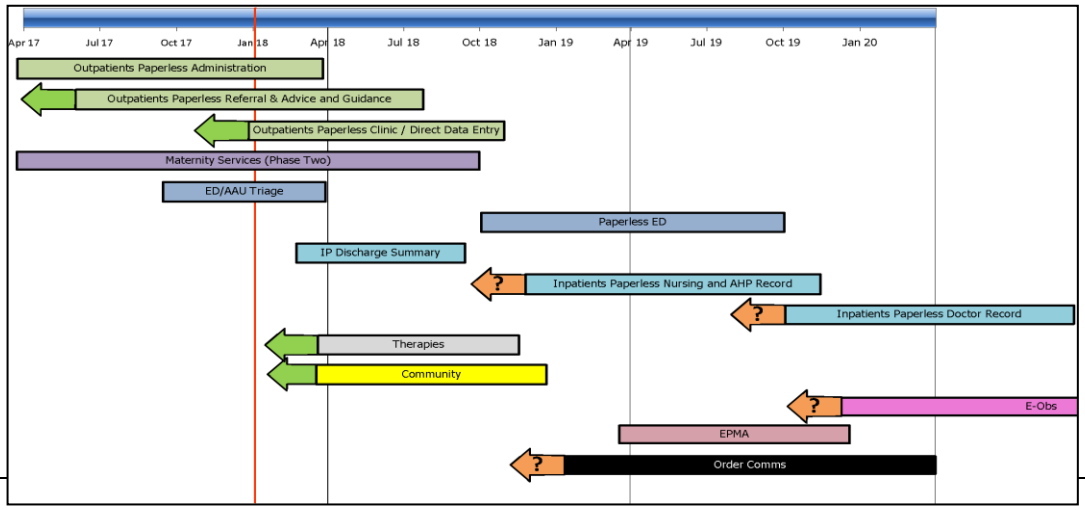
Progress in period

Overall Programme

- Robust governance from programme through projects and individual work streams established
- Assurance through local assurance groups against plan. Actions tracked weekly.
- Range of Key Performance Indicators established to monitor delivery of programme against plan.
- Significant in-roads in terms of programme and project KPI's and benefits plan with support from Organisational Learning and Improvement team.
- Transfer of Prison telemedicine operational to outpatient; aligned with existing Trust Referral to Treatment governance processes.
- Work stream to deliver telemedicine for outpatient consultations now brought into IHR Programme Board.
- Overall programme status is Green. Increasing levels of engagement from a range of areas/groups/staff.

Outpatient Administration

- Rolled out through 5 out of 10 hubs with some functionality.
- Stakeholder engagement workshops in November have helped to re-define some work streams.
- Expediting phase 2 (direct data entry into SystmOne) to February-March 2018 for early adopters.
- Continuing rollout of new working practices through admin hubs.
- Benefits measurements and work has increased pace and depth.
- Pilot of new Electronic Referral Service (advice and guidance) within pilot specialties.
- Cost Improvement Plan (CIP) associated with this project achievable.
- Recruitment of two implementation support posts to support embedding of standard processes and implementation of S1 for admin and clinical areas.
- TPP shadowing and 'gap analysis' in January to prioritise SystmOne developments for existing functionality as well as those to enable outpatient project.



Maternity Services Phase 2

- Progressing well with clinical and midwifery engagement.
- Transitioned to a new project manager.
- Revised timeline to deliver a paperlite maternity service with go live in November 2018.
- Additional capital funding identified to deliver equipment to support successful implementation.

Emergency Department (ED) Triage

- Cover for project sponsor provided by Assistant Director of Operations.
- ED department rationalised existing paper documentation for adult and paediatric patients.

Plan for next period

Digital Strategy

- The senior management team are working to host a Digital Strategy event on 2nd February, including patient and local population represented to ensure IM&T and Clinical Strategies support a 'Digital Airedale in 2020 and beyond'. 90+ delegates currently due to attend including Chief Nurse from NHS Digital and CCIO Leeds and York Partnership NHS Foundation Trust.

Partnership Working (TPP)

- Trust to sign off Memorandum of Understanding with TPP.
- We are working closely with TPP to co-design an agreed timeline that enables the delivery of a 'fully functioning secondary care product in 2018/9' (John Parry, Clinical Director TPP). This should include Observations & Escalation, and Order Communications.
- Clinical Director (IHR) to establish governance arrangements for (non-contractual) relationship with TPP including mechanisms for holding to account, identifying risks and issues that exist outside the contract.

IHR Programme

- Lead for Transformation developing the business case to take to Executive Delivery Group in March 2018 to deliver the full electronic patient record in 2018-20.
- Populate and embed programme Key Performance Indicators, ensure benefits realisation is embedded within the projects.
- Complete IHR for Community and Therapy Services. Original Planned Date Dec 2020 – Revised Date Jan 2018.
- Complete IHR for Therapy Services. Original Planned Date 12/20 – Revised Date 11/17.
- Carry out Readiness assessment for potential early adopters including Acute Assessment Unit/Ambulatory Care Unit, in-patient nursing documents.
- Increase engagement and communications with all stakeholders and partner organisations.
- Use of YouTube video guides to enable greater access to training materials.

Outpatient Project

- Deliver direct data entry (clinical annotations) into SystmOne through a range of hubs for early adopters.
- Implement electronic radiology requesting 30th January Trust wide followed by paper switch off.

- Deliver ICE pathology and radiology requesting, filing and reporting Trust wide.
- Roll out the use of SystmOne tasks to all administrative hubs to ensure safe transition of paper to paperless processes for clinical delivery (e.g. internal referrals).
- Roll out remaining functionality to existing hubs that have gone live.
- Roll out of remaining functionality to hubs – Obs & Gynae, Diabetes and Elderly, Surgery.
- Retrospective benefits mapping for areas already live.
- Deployment of second monitors to expand clinical desktop.
- ESR/Advice & Guidance workstream fully embedded within IHR.

Maternity Project

- The project team is currently working through business analysis, benefit mapping and system design for Phase two of the Project which is scheduled to be fully live by November 2018.
- Complete labour and delivery scoping, Continue with ongoing completion of benefits tracker.
- Continue with communications, to increase engagement.

ED Triage

- Project Manager working on triage process map, which will serve as blueprint for the S1 'build' by IT.

Therapies & Community

- Review existing Project scoping once posts in place. Commence SystmOne Build for both Projects.

Telemedicine

- Finalise and agree commercials with provider and Supplies for a pilot. Identify how the pilot is to be funded.
- Pilot areas to include Cancer survivorship, HODU chemotherapy assessment and GoldLine.
- Ensure that robust processes established to embed TM as a method of delivering routine outpatients appts.

Key Risks

- That CIP will not be delivered if insufficient processes are made paperless, preventing the removal of paper notes from outpatients. Partially mitigated by appointment of implementation support, improved project governance and focused business analysis work.
- Additional requirements for equipment (e.g. webcams, extra monitors) will be an additional cost pressure.
- Sufficient Organisational Learning and Improvement team resource to support business analysis, benefits and organisational change.
- Additional costs required to roll out IHR (monitors, additional PC's, webcams, new processes, data quality).

Challenges

- Ability to deliver training to staff to enable basic S1 access as well as extended functionality such as outpatient consultations. Mitigated by use of video(s) guide using Captivate software, SOP's.
- Acute and medium term staffing issues within IT. Mitigated by focus on priority areas for delivery by IHR team. Utilise early adopters to propagate energy.