Yeovil District Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS
PART I

This is to advise that there will be a meeting of the Board of Directors at 9.00 am
on Wednesday 16 May 2012
in the Boardroom, Level 1, Yeovil Hospital NHS Foundation Trust

AGENDA

Welcome to Paul Mears, Chief Executive

Welcome to Margaret Robathan, Governor (A governor will attend each Board Meeting as an Observer)

1. **DECLARATIONS OF INTEREST**

   Members of the Board are required to make known any interests relating to items on the current agenda

2. **APOLOGIES:**

3. **MINUTES OF THE PREVIOUS MEETING HELD ON 18 APRIL, 2012** Appendix 1

   To APPROVE the Minutes of the Board of Directors' meeting held on 18 April, 2012.

4. **ACTION SHEET** Appendix 2

5. **MATTERS ARISING**

6. **CHIEF EXECUTIVE'S BRIEFING** Appendix 3

   To DISCUSS the key current issues affecting the Trust.

7. **DEMENTIA PROGRESS REPORT** Appendix 4

   7.1 **PATIENT STORY**

8. **ITEMS FOR APPROVAL**

   8.1 **ANNUAL PLAN** Appendix 5

   To APPROVE the Annual Plan

   8.2 **COMMITTED FACILITY** Appendix 6

   To APPROVE the Committed Facility.

9. **PERFORMANCE, RISK & ASSURANCE**

9.1 **PERFORMANCE REPORT – MONTH 12 MARCH 2012** Appendix 7

9.1.1 **ESTATES & FACILITIES REPORT** Appendix 8

9.3 **ASSURANCE REPORT**

9.3.1 Non Clinical Risk Assurance Committee Report - following the meeting held on 15 May, 2012 Verbal

10. **ITEMS TO NOTE**

10.1 **NUTRITION** Appendix 9

To NOTE the Nutrition Update.

10.2 **YDH'S POLICY ON DISCHARGE AT NIGHT** Appendix 10

To NOTE YDH's Policy on Discharge at Night.

11. **ANY OTHER BUSINESS**

12. **DATE AND TIME OF NEXT MEETING**

There will be a meeting of the Board of Directors on Wednesday 13 June 2012 at 9.00 am to be held in the Boardroom, Level 1, Yeovil District Hospital. The 25 and 35 year Long Service Award Ceremony will be held at 2.15pm in the Garden Restaurant.

APPENDIX 2
BOARD OF DIRECTORS
16 MAY 2012

BOARD OF DIRECTORS – ACTION SHEET

16 May 2012

Minute	Action	Outcome	Due	By
52/12	**Associate Directors' of Nursing Report –** Provide an update on nutrition arrangements in the Trust	On today's agenda	16 May 2012	SJ
74/12	**Quality Strategy** – Provide report on Trust policy on discharge at night	On today's agenda	16 May 2012	SJ
74/12	**Quality Strategy** – Circulate draft Quality Report to Board members	This is on todays' Part 2 agenda	16 May 2012	SJ
77/12	**Updated Strategy** – Consider how to communicate this vision effectively	In progress	11 July 2012	JM
79/12	**Action Sheet** – Set date for providing report on Theatre investment	Options appraisal to go to HMT on 26 June	Dependent of HMT decision	JHig
82/12	**Investment into Emergency Department –** Report on metrics associated with this investment and need for risk budget	Update at meeting	16 May 2012	JHig
90/12	**Any Other Business** - Include a paper on each Freedom of Information request	This is on todays' Part 2 agenda	16 May 2012	SC

Yeovil District Hospital NHS
NHS Foundation Trust

Forward Plan Strategy Document for 2012-13

Yeovil District Hospital NHS Foundation Trust

Section 1: Forward Plan

A. The Trust's vision is summarised as:

The Board of Governors, Board of Directors and Hospital Management Team have set out an ambitious vision that:

Yeovil District Hospital should become the new model of how a rural DGH can excel at serving its local community

We call this moving from hospital to healthcare – no longer seeing ourselves as simply a hospital, but as working with our partners to provide a wider range of health services within a much more joined-up system of care (often called integrated care).

Our aim is not simply to survive but to thrive and to do this Yeovil District Hospital needs to maintain a secure, high quality emergency service for the local population. This will be complemented by a wider range of other services which offer convenience and quality to local people, attract and retain the highest calibre staff, and offer additional income to support our core services. The new model therefore has two components:

Yeovil District Hospital – The General Hospital

- A strong emergency service run by Yeovil District Hospital
- A general medical & surgical service, including complementary elective services
- A small number of exemplar specialisms

Yeovil District Hospital – The Integrated Care Provider: extending Yeovil District Hospital's role as a key provider of joined-up (integrated) services designed around patient needs

- Developing new integrated pathways of care with our partner organisations
- Hosting a broader range of integrated services provided by ourselves and partners: NHS, private, voluntary sector
- Working across pathways & the community, not just in hospital
- Providing care from a range of convenient locations
- Extending our geographical reach
- Helping people to stay well.

In order to deliver this new model, the Board of Directors has identified six strategic areas of focus, each of which is supported by a strategy which sets out the approach to developing our strengths in these areas:

Quality: Personal, high quality and safe care

At the heart of everything we do is the provision of the best possible care, with patients treated as individuals by dedicated, skilled staff. We also need to be able to demonstrate that we provide high quality care by collecting more feedback from patients, and more information about the quality of our services.

Clinical Services: Strong, sustainable services, meeting local needs

We will focus our expertise and resources on strong acute core services, and work with partners to develop a clinically and financially sustainable range of other hospital and community services which meet local needs.

Workforce: Valuing our staff as our greatest strength

We will make sure Yeovil District Hospital is a great place to work, with strong clinical leadership, where staff feel involved and valued, so we can attract and retain the best staff.

Partnerships: A valued partner in the local health service

We will be a stable, influential partner, helping to shape the local health service and working together to provide better services for patients.

Finance and Commercial Focus: Managing our money wisely

We will constantly focus on finding new ways to improve quality and efficiency, which enable the Trust to continue to deliver its vision in a changing financial climate. We will work with partners to ensure our valuable resources are used in the most efficient manner. We will also develop new income-generating services, working with partners where there is an advantage in doing so, to support our core NHS services.

Infrastructure: Infrastructure that supports delivery

We will invest in our information systems to support the redesign of care delivery and improve quality and safety. We will maintain the basics in terms of our equipment and buildings, exploring new ways to drive more efficient ways of working.

B. The Trust's strategic position is summarised as:

The Health and Social Care Bill will create a landscape characterised by greater competition between providers of health services with much more involvement of the private sector and potentially new types of organisations including social enterprises and mutual organisations. Patients will also be given greater opportunity to choose providers informed by a wider availability of comparative data and patients' own views about the care they've received. In support of this there will be increased transparency about clinical outcomes, quality and patient experience.

One of the key aims of the reforms is to deliver an NHS which is clinically led and managerially supported. To reflect this we will see the abolition of SHAs, with PCTs replaced by GPs and other primary care professionals who will be responsible for the commissioning of services from a wide range of potential providers. There will be less 'systems management' with the 'shape' of the NHS being determined by the commissioning choices of the new clinical commissioning groups and competition between providers. With the emerging Academic Health Science networks, designed to promote and spread innovation, there are opportunities to contribute towards further improving the quality of services across the region.

As well as these changes we can also expect that demand for services and public expectations will continue to rise. We know that the economic constraints on public funding are likely to be a significant and continuing feature, not only with less investment for public services, but also the social impact of this austerity on the health and wellbeing of the population.

The major threats to our hospital relate to the scale of the financial challenge and the pace at which the structural changes will come into effect. Greater competition from existing NHS and private sector organisations, but also from new ones, could result in a loss of income and in a time of limited resource there will be the risk of tensions between organisations who may be pursuing conflicting strategies to our own.

However, there are significant opportunities for us to strengthen and consolidate our position as the principal provider of acute care locally, and also to extend our reach and develop as a key provider within a joined-up or integrated system of healthcare where organisational boundaries become less important. We need to be nimble and adapt quickly, keep a firm grip on our finances, build on our existing partnerships and create new ones.

Despite the challenges ahead Yeovil District Hospital is well placed to meet them and take advantage of the opportunities presented. Our major strengths as a hospital include the commitment and loyalty of our workforce whose strong caring ethos is embodied in our iCARE philosophy. Getting it right on a personal level will be fundamental to being the hospital of choice for local people and their GPs. As a Foundation Trust we also enjoy considerable support from the local community particularly from our membership and elected Governors. Increasingly we need to find new ways of engaging our community in shaping the future of their hospital.

As well as these strengths we also have a good track record of delivery and sound financial performance. In recent years we have made good progress with our clinical services strategy, originally developed in 2008, and have strengthened some core acute services within the hospital. The care we provide is generally of a high quality and feedback from our patients is positive. We have also made real progress in terms of improving our patients' experience and safety within the hospital. We are a recognised centre of excellence for research and development.

Nevertheless we know that there are some aspects of our clinical services that could be improved and strengthened. It is vital that all of the services we deliver are of the highest standard, appropriate for a hospital like ours and are clinically sustainable, efficient and safe. We also know that parts of our infrastructure, particularly our information systems and the hospital buildings, do not always reflect the quality of our services or our ambitions to improve them.

Although financially sound we all need to take greater care of how we use our money to be sure that we remain financially viable in the longer term. We know that in many areas we provide services efficiently, but we also know that there is room for improvement in others. There are also opportunities to change our ways of working to raise quality and increase productivity to ensure we deliver better services within planned resources, for example by avoiding the use of temporary capacity which is expensive and not always the best for patients and staff.

As a hospital we have sought to develop partnerships with neighbouring providers but it is clear that to be successful in the future we need to develop a wider range of alliances not solely with the NHS but also potentially with the private sector and other types of organisations.

Clinical and Quality Strategy

C. The Trust's Clinical and Quality strategy over the next three years is:

Quality Strategy

The Trust reviewed its Quality Strategy in 2011, setting out a 3 year vision to become the local provider of choice and by 2014 to be recognised as the best small trust in respect of Hospital Standardised Mortality Ratio, to be respected for listening to what our patients tell us and changing for the better, and to become the best small trust in respect of incident reporting, whilst continuing to reduce those that result in harm to our patients.

The quality strategy makes explicit our commitment to patient safety, clinical outcomes and the patient experience through setting challenging targets that will show our patients we are the local provider of choice. We will ask ourselves and our patients: How good is our care? How do we know we are improving? and how do we compare, both with ourselves and others?

The three main priorities of the quality strategy build on Lord Darzi's 'High Quality Care for All' (2008) and focus on patient experience, clinical outcomes and patient safety. The Quality Strategy sets out the following objectives:

Patient experience
To build on the Trusts iCARE philosophy and be recognised for listening to what our patients tell us. To develop an inclusive programme that seeks to understand what all of our patients want and is pivotal to service improvement and our transformation programme.

Outcomes
To become the best small trust in respect of Hospital Standardised Mortality Ratio (HSMR), improving year on year.

Patient safety
To become the best small trust in respect of incident reporting, whilst at the same time reducing the number of incidents that result in harm to our patients.

The Trust's iCARE principles are our core values, and this drives our journey forward. These values mean that we will:
COMMUNICATE effectively
Show a positive ATTITUDE
Have RESPECT for our patients, carers and colleagues
Maintain an ENVIRONMENT that is conducive to care and recovery

Clinical Services Strategy

During 2011/12 the Trust also reviewed its Clinical Services Strategy for the next three years.

The Trust recognises that it has a strong track record of delivering acute, hospital based services across its historic catchment area. However, to prosper in the new environment the Trust is looking to both strengthen these 'core' services and also develop the range of services it provides in order to move it from a hospital to a healthcare provider as part of an overall system of integrated care which we are developing with our local partners.

The following principles have been agreed to progress this strategy:

- The Trust will continue to provide a broad range of clinical services
- The core function of YDH will remain the provision of emergency services; a range of other services will continue to be required to support the core and ensure that it remains both clinically and cost effective.
- Only services that can continue to be delivered to a high quality will be maintained as part of the service provision of the Trust.
- The Trust will develop service provision in a range of locations where services can be provided cost effectively and where there is a strategic advantage in doing this, prioritising outpatient services at South Petherton, the Yeatman and West Mendip Hospitals and through the development, in partnership, of the Yeovil Health campus
- The Trust will build on the successful strategy of working with a range of partners in support of the delivery of its portfolio of services.
- The financial contribution of each service will be maximised.
- All services should move towards upper quartile national performance against a range of indicators. These indicators include mortality rates, daycase rates, new to follow up ratios for outpatients, readmission rates and waiting times.
- The Trust will look to develop a small range of exemplar services to be offered over a wider geographical area.

In line with these principles, the Trust has developed a new overarching approach to services at the hospital which we call moving from hospital to healthcare – no longer seeing ourselves as simply a hospital, but as working with our partners to provide a wider range of health services within a much more joined-up system of care (often called integrated care).

Our aim is not simply to survive but to thrive and to do this YDH needs to maintain a secure, high quality emergency service for the local population. This will be complemented by a wider range of other services which offer convenience and quality to local people, attract and retain the highest calibre staff, and offer additional income to support our core services. The new model therefore has two components:

YDH – The General Hospital

- A strong emergency service run by YDH
- A general medical & surgical service, including complementary elective services
- Consultant-led maternity and paediatric services
- A small number of exemplar specialisms offered over a wider area

YDH – The Integrated Care Provider: extending YDH's role as a key provider of joined-up (integrated) services designed around patient needs

- Developing new integrated pathways of care with our partner organisations
- Hosting a broader range of integrated services provided by ourselves and partners: NHS, private, voluntary sector
- Working across pathways & the community, not just in hospital
- Providing care from a range of convenient locations
- Extending our geographical reach
- Helping people to stay well.

Clinical and Quality priorities and milestones

Quality Priorities

The quality strategy milestones are being achieved ahead of time and it is likely that the current strategy will be reviewed at the end of the year with a plan for the next 3 years that further integrates clinical process improvements with quality outcomes.

Key milestones in the current quality strategy include:

- A 2.5% year on year reduction in mortality, supported by the introduction of more care bundles
- Further improvement in the care of dementia patients by achieving the South West level 2 standards
- Continued involvement in the national Patient Reported Outcome Measures
- Embedding the use of local patient experience information to inform quality and service improvements
- Maintaining VTE assessment standards and a zero tolerance approach to hospital acquired incidences.
- Maintaining best practice in Healthcare Associated Infections.
- A further reduction in patient falls, a focus on reducing falls that result in harm, and a reduction in the number of patients who fall more than once.
- Continuing to support the reporting of clinical incidents with an increase in no harm or near miss reporting and a decrease in incidents that cause harm
- Implementing the 'Safety Thermometer' and recording the number of patients receiving harm-free care.
- Decreasing the number of hospital acquired pressure ulcers with zero tolerance of grade 3 and 4 pressure ulcers.

D. Clinical and Quality priorities and milestones over the next three years are:

For 2012/13 the Trust has agreed the following milestones which will see the Trust:

- Further reduce HSMR by 2.5%
- Reduce SHMI by 2% (the new Department of Health mortality indicator)
- Reduce patient falls by 10%
- Reduce the number of patients who fall more than once by 15% (Governors' Key Performance Indicator)
- Introduce the safety thermometer across the Trust
- Reduce the number of hospital acquired pressure ulcers (grade 3 or 4) by 25%
- Increase the number of patients completing in-house satisfaction surveys
- Reduce healthcare associated infections – in line with the local targets (MRSA, Clostridium difficile & MSSA)
- Maintain our involvement in the programme of patient safety improvement as set by NHS South West
- Develop two more in-house Patient Reported Outcome Measures
- Ensure that 95% of complainants receive a response within the agreed timescale
- Reduce the number of complaints where we re-negotiate the agreed timescale for completion
- Increase the number of EXIT questionnaires received by 20% -
- Continue with the development and roll-out of care bundles, in particular for Dementia, Naso-Gastric tube insertion and Community Acquired Pneumonia.
- Improve the accessibility of information available for patients with a learning disability. This will be achieved by updating the internet and intranet site and by reviewing and amending key information leaflets such as the Patient Advice and Liaison service and "Welcome to YDH".

Progress against these priorities will be monitored by the Clinical Governance Delivery and Assurance Committees with monthly updates to the Board of Directors.

Clinical Services Strategy

In order to deliver the vision for the Trust's clinical services two broad strategic priorities for the next three years have been developed. These are:

- To ensure that the Trust's general hospital services are high quality, efficient and sustainable;
- To develop the hospital to healthcare vision in order for the Trust to become a key provider within an integrated care system designed around the needs of patients in South Somerset, North Dorset and beyond.

To support these priorities the following priorities and milestones have been identified:

CORE EMERGENCY SERVICE

Year 1: 2012/13 Strategic Milestones	Year 2: 2013/14 Strategic Milestones	Year 3: 2014/15 Strategic Milestones
1. Secure Trauma Unit Status 2. Complete a workforce review of the emergency department 3. Implement a new model for acute surgical admissions 4. Implement a service transformation project focussed on streamlining the emergency care pathway	1. Deliver on site consultant physician presence, 12 hours a day, 7 days a week	1. Implement new model for urgent and emergency care 2. New model for 24/7 Consultant paediatrician cover

KEY SERVICES CRITICAL TO THE EMERGENCY SERVICE

Year 1: 2012/13 Strategic Milestones	Year 2: 2013/14 Strategic Milestones	Year 3: 2014/15 Strategic Milestones
5. Review acute stroke service 6. Address capacity issues in endoscopy 7. Review gynaecology service 8. Maximise financial contribution of orthopaedics 9. Strengthen on site oncology 10. Implement new model for pathology	2. Move to a closed critical care unit 3. Review capacity requirements on Level 10 4. Develop networked approach to radiology 5. Strengthen pre-assessment	3. Achieve CNST level 3

SERVICES NOT DIRECTLY SUPPORTING THE EMERGENCY SERVICE

Year 1: 2012/13 Strategic Milestones	Year 2: 2013/14 Strategic Milestones	Year 3: 2014/15 Strategic Milestones
11. Service reviews - neurology and dermatology 12. Service reviews - ophthalmology, oral surgery/orthodontics, community dentistry and paediatric orthopaedics 13. Review of tertiary paediatric services 14. Implement revised model for SCBU 15. Strengthen Head and Neck cancer services 16. Develop the breast service	6. Service reviews – thoracic surgery, osteoporosis 7. Service reviews – audiology, ENT 8. Cease nuclear medicine 9. Explore expansion of midwife led maternity services	4. Review community paediatric service

HOSPITAL TO HEALTHCARE

Year 1: 2012/13 Strategic Milestones	Year 2: 2013/14 Strategic Milestones	Year 3: 2014/15 Strategic Milestones
17. Commence consultation and procurement exercise for Health Campus 18. Implement reablement services 19. Secure commercial partner for private service provision	10. Service delivery on Health Campus commences 11. Maximise opportunities to increase service provision at community locations 12. Further extend the community pharmacy model	5. Implement community-based models for diabetes and rheumatology

Financial Strategy

E. The Trust's financial strategy and goals over the next three years:

Income and Expenditure

Summary

The financial position for 2011/12 resulted in the Trust delivering a surplus of £797,000 which was in excess of the annual plan and delivered a risk rating of 3. The surplus before technical accounting adjustments was £993,000. The financial plans for the next three years are to maintain a strong financial performance and deliver an income and expenditure surplus of between £0.6 million and £0.8 million, before technical adjustments, resulting in a financial risk rating of 3.

Income

The income in 2012/13 has increased over the 2011/12 level as a result of being awarded a contract for delivering additional outpatient services at South Petherton Hospital and growth in non-tariff services for intensive care, the special care baby unit and additional drug costs that are not included within tariff payments. Income levels are then expected to reduce in 2013/14 and 2014/15 due to a fall in demand for elective services and the deflator applied to the National Tariff. This will result in the income reducing from £109.2 million in 2012/13 to £108.0 million in 2014/15. A key element of the Trust's strategy is developing the Yeovil Health Campus but as plans for this are in their relative infancy the financial impact has not been factored into these plans. Plans are in place to increase the private patient income from £2.6 million in 2011/12 to £2.9 million by 2014/15 by improved marketing and developing new services.

Expenditure

At Yeovil District Hospital there is a culture of service improvement in all of the services that are provided to ensure there is a focus on improving the quality of services whilst increasing efficiency. In 2011/12 a cost improvement programme of £4.8 million was delivered (4.4% of turnover) as planned. Of this £2.7 million related to workforce savings as a result of reducing high cost temporary staffing and improved efficiency within the urgent care pathway, resulting in less additional capacity having to be opened in the winter months. Workforce plans are being developed to reduce the cost of the workforce over the next three years. Within the Trust plans for the next three years are cost improvement savings of £4.6 million in 2012/13, £5.4 million in 2013/14 and £5.4 million in 2014/15.

The pay costs included within the financial plans show pay increasing in 2013/14 due to an assumption that there will be a pay award as the two year national freeze will have finished and then pay will reduce in 2014/15 due to efficiencies and workforce strategies.

The Trust's strategy of moving from hospital to healthcare will continue to develop over the next three years. This strategy will include working with our partner organisations to develop integrated services which will deliver more efficient services and healthcare across the health economy. As these plans are in their infancy the financial impact is not yet known and therefore is not modelled into the three year plan. There will be investment into some services in 2012/13 so that best practice tariffs can be achieved, namely an appointment of an ortho-geriatrician post.

It is anticipated that drug costs will increase over the plan period from £7.6 million in 2011/12 to £9.8 million by 2014/15.

Depreciation costs were £3.4 million in 2011/12 and these will increase to £3.9 million by 2014/15 due to the continued investment in the estate.

Capital Investment

There was £3.6 million invested in capital developments in 2011/12. This included expanding the Macmillan Cancer Unit (£0.5 million) and £1.2 million spent on medical equipment including the upgrading of radiology equipment. A new combined heat and power unit was commissioned during the year (£0.5 million) which enables the hospital to produce some of its own energy making savings on utilities, and £0.8 million was spent on enhancing the quality of the building and estate.

The planned level of capital investment in 2012/13 is £3.0 million, £3.9 million in 2013/14 and £4.2 million in 2014/15. The Trust is planning on investing in IT systems over the three year period (£2.2 million) and also a continued investment in medical equipment (£4.1 million) which includes a replacement CT scanner. The improvements to the estate amount to £2.2 million which include a major refurbishment to the women's hospital.

Liquidity

The liquidity position remained strong at the end of 2011/12 with a £6.1 million cash balance. The planned cash balance for 2012/13 is £6.2 million, for 2013/14 £5.5 million and for 2014/15 £5.4 million. The reduction in cash is due to the completion of capital programmes funded through previous years' surpluses.

In order for the Trust to deliver the financial strategy the cost improvement programmes of £4.6 million in 2012/13, £5.4 million in 2013/14 and £5.4 million in 2014/15 need to be achieved. During 2011/12 the Trust established a programme management office to oversee the cost improvement programmes and to ensure that there is rigour in the project management arrangements.

Leadership and Organisational Development

F. The Trust's approach to ensuring effective leadership and adequate management processes and structures over the next three years is:

The Trust has a model of strong clinical leadership, and each of the three clinical divisions is led by a senior consultant, who is also a member of the Hospital Management Team. The divisional teams, the Executive Team and the Board take part in regular reviews (at least annually) of their effectiveness, and the changes they need to make to their ways of working to support the changing organisational strategy.

The Board has identified that it needs to grow the level of capacity and capability in the organisation in a number of key areas to deliver its strategy, particularly around change management, commercial skills and the move towards integrated care.

To enable it to deliver this ambitious agenda, the Trust has launched a Transformation Programme.

The key areas within the programme are:

- Reviewing clinical pathways both within the Trust and with our partners as part of a more joined-up system of care;
- Becoming an integral part of the community through the provision of services at community hospitals such as South Petherton and the Yeatman Hospital in Sherborne;
- Transforming how we work to support an integrated care pathway;
- Investing in IT to maximise the efficiency of our services;
- Growing our commercial capability to enable us to move into new markets;
- Ensuring we are getting best value for our goods and services through effective procurement processes.

Within each of these areas are a number of important projects – more than 50 in total. To ensure these are co-ordinated, have the resources they need, and that risks and issues are managed, a Programme Office has been set up. The Programme Office provides regular reports on progress to the Board, and works with the Academy to ensure that appropriate training and support are in place for those involved in the projects.

21 project managers have been recruited from clinical and non-clinical roles within the organisation who will take time out of their regular jobs to support key projects across the hospital. The Trust is also investing in some external support in respect of key projects to ensure the resources are in place to deliver this challenging programme. For example the NHS Institute is supporting work on the stroke pathway, and the Department of Health's Emergency Care Support Team is working with the Trust on a set of projects aimed at improving our emergency care services.

Reviews are also taking place of all the Trust's non-clinical services to ensure they are set up in the most effective and efficient way to support the Trust's Clinical Services Strategy.

In the recent non-executive recruitment exercise these factors were taken into account in selecting the four new non-executives who will be joining the board over the next 12 months, and who bring extensive change management, organisational development and commercial skills.

The new chief executive brings a wealth of experience in developing systems of integrated care from his time working in Torbay.

A commercial manager has also been appointed to lead on the implementation of the Trust's commercial strategy.

Other Strategic and Operational plans

G. The Trust's other strategic and operational plans over the next three years:

The Trust will be investing in the development of an Electronic Health Record over the next 3 years, which will include replacing the existing dated clinical systems, and moving to paperless records with information shared across different organisations to support integrated care. This will include a significant move towards mobile technology, which will enable many new ways of working, leading to quality and patient safety improvements.

Procurement is taking place during 2012/13, with the first systems implemented in 2013/14. The Trust has identified £2.2M capital to support this programme, but is also part of the Southern Acute Programme which may see the Trust benefit from central funding, enabling the release of local capital to support other priorities. A Head of IT Transformation has been appointed on a fixed term contract to oversee the programme and ensure that it enables major improvements to services, and that the full benefits are delivered.

Regard to the views of Trust Governors

H. The Trust has had regard to the views of Trust Governors by:

The Forward Plan is an expression of the present stage of the Trust's developing overall Strategy. As such the Board of Governors have been engaged throughout the year in its development.

The Board of Governors has a Strategy Working Group which meets on a quarterly basis ahead of the full Governors' meeting. These Group meetings are attended by the Chief Executive, the Director of Planning & Performance and other relevant directors depending on the business of the meeting.

The remit of the Strategy Working group is to work systematically through the elements of the Trust's strategy, considering each component it turn and discussing the way in which it is being shaped, factors requiring modification of earlier plans and how the particular part contributes to the whole forward plan.

The Group then reports to the full Board of Governors' meeting, where the Chief Executive and Chairman are able to discuss any issues the Board would like to pursue.

Throughout the year the Strategy Working group contributed to not only the development of the overall 'Hospital to Healthcare' theme, but also to the further evolution of the following elements: Quality Strategy; Workforce Strategy; Estates Strategy; IT Strategy, Clinical Services Strategy and the development of the Transformation Programme.

Governors are also routinely invited to be involved in Trust committees and groups that are involved in developing the more detailed aspects of strategic plans.

Nearly half the Board of Governors attended a major half-day workshop including directors, GPs and local stakeholder organisations to consider the strategic opportunities represented by what has become known as the Yeovil Health Campus development.

In this way the Governors are able to contribute to the overall shape of the strategic direction and also debate in detail its various themes. So the Board of Governors is not only informed of, but helps to inform, the production and finalisation of this forward plan.

The appendices have been redacted on the grounds of commercial sensitivity.

Yeovil District Hospital NHS
NHS Foundation Trust

APPENDIX 5
BOARD OF DIRECTORS
16 May 2012

Report to:	Board of Directors
Report from:	Director of Planning & Performance
Subject:	Annual Plan 2012/13
Date:	16 May 2012

1 Introduction

1.1 Each year every Foundation Trust is required to submit an Annual Plan to Monitor setting out its strategy and financial forecasts for the next three years.

1.2 The submission consists of four elements:

- Strategic Plan template: this sets out the organisation's strategy, key clinical, workforce, service and financial objectives, and key risks for the next three years
- Financial Plan template: this sets out the detailed financial forecasts for the next three years, together with information about membership, governors and a set of Board Statements on governance and risk management which the Board must sign off.
- Mandatory goods and services template: this sets out planned activity and income for all of our services in 2011/12 by commissioner
- Mandatory education and training services: this set out details of the contracts the Trust holds to provide education to third party organisations

1.3 The Strategic Plan template is now attached for approval, together with the key financial plan templates, finance risk indicators, Compliance Framework risk declaration and board statements on governance and risk management, all of which need to be approved by the Board.

2 Strategic Plan Template

2.1 The purpose of the template is to provide Monitor with assurance that the Trust has a robust strategy and a coherent set of plans to implement it. The first section will be a public document available on Monitor's website.

2.2 The Strategic Plan template is fully consistent with the Trust's Strategy and its associated implementation plans.

2.3 The Board is asked to APPROVE the strategic plan template for submission to Monitor. This is attached at Annex A.

3 Financial Plan Templates

3.1 The table below sets out the key financial assumptions which under-lie the development of the plan, and which were agreed at the last board meeting:

	2012/13	**2013/14**	**2014/15**
Target surplus	£500k	£500k	£500k
Target financial risk rating	3	3	3
CIP %	4.0%	5.0%	5.0%
CIP	£4,630k*	£5,400k	£5,400k

3.2 The summary financial templates, which have been prepared on this basis, are attached at Annex B for approval.

4 Finance Risk Indicators

4.1 The financial templates include a set of risk indicators which Monitor consider to highlight the potential of future material financial risk. These are attached at Annex C. All of these have been assessed as FALSE, i.e. none of the leading indicators of financial risk have been triggered. The Board is asked to approve the finance risk indicators.

5 Compliance Framework Declaration Of Risk

5.1 The Annual Plan submission includes a tab entitled “Declaration of risks against healthcare targets and indicators for 2012-13.” These are the performance standards set out in the new Compliance Framework and will form the basis of the quarterly reports to Monitor. This is attached as Annex D. For each target or indicator the Board is required to declare whether it believes there is a risk to achieving the performance over the year. This is a simple yes or no answer; ‘not applicable’ is not an option.

5.2 No risks to the achievement of the targets and indicators have been declared on this template, based on current performance and the plans put in place to maintain this.

5.3 If the Board agrees this declaration, this will score 0 and mean the Trust will be rated Green for its annual plan governance risk.

6 Board Statements on Governance and Risk Management

6.1 The final tab to be completed on the Annual Plan template is the Board statements as set out in Annex E. This has been completed with the Board confirming that it has all appropriate measures in place to ensure compliance with all requirements, with the exception of Information Governance.

6.2 While the Trust's Information Governance Toolkit performance improved during the year, the Department of Health made all 45 standards key requirements, whereas last year only 22 were. The Trust achieved level 2 in 39 of the 44 that apply to the Trust, as discussed at the Board meeting in March 2012.

6.3 The 5 standards which the Trust did not achieve at level two covered the areas of:

- Ability to audit access to personal records: the Trust's clinical systems do not have this functionality, and the Trust will be unable to achieve this standard until the procurement of new systems is completed during 2013/14 to 2014/15.
- Pseudonymisation: this requirement cannot be achieved until all other requirements are at level 2 or above
- Accuracy checks on service user data: the achievement of this standard would require additional staff, and the Board has decided to tolerate this risk which is considered to be low. There are many existing checks in place, which the Board has assessed as adequate.
- Corporate records: procedures and audit. The Trust has set up a transformation project to resolve these issues, which will use Sharepoint as the enabling technology. Sharepoint is being rolled out across the Trust by December 2012. The Board has assessed these two areas as posing a low risk to the organisation.

6.4 The Trust's Information Governance arrangements were reviewed by the Internal Auditors during 2011/12, and also by the Non-Clinical Risk Assurance Committee, both of which gave an assessment of Green against the arrangements in place to ensure governance standards are met.

7 Recommendation

7.1 The Board is asked to APPROVE the content of the submissions to Monitor as set out above.

APPENDIX 1

BOARD OF DIRECTORS

Minutes of a meeting of the Board of Directors held on Wednesday 18 April 2012 at Yeovil District Hospital

Present:	Peter Wyman [PW]	Chairman
	Libby Walters [LW]	Acting Chief Executive
	John Buckley [JB]	Non-Executive Director
	Amanda Ellingworth [AE]	Non-Executive Director
	Julian Grazebrook [JG]	Non-Executive Director
	Jonathan Higman [JHig]	Director of Operations
	Jonathan Howes [JHo]	Medical Director
	Sue Jones [SJ]	Director of Nursing & Clinical Governance
	Jeremy Martin [JM]	Director of Planning & Performance
	Pippa Moger [PM]	Acting Director of Finance
	Alison Rayner [ARa]	Director of Human Resources
	Alexander Russell [ARu]	Non-Executive Director
	Robert Steele [RS]	Director of Facilities
	Gill Waldron [GW]	Vice-Chairman

In Attendance:

Caro Morgan	Public Governor
Simon Chase [SC]	Company Secretary

Action

72/12 **DECLARATIONS OF INTEREST**

The Chairman reiterated that he had been a partner in PwC until 30 June 2010 but that he no longer shared in their profits.

No other interests were declared.

73/12 **APOLOGIES AND WELCOME**

The Chairman welcomed Caro Morgan, public governor, who was observing the Board meeting.

The Chairman explained that, in the light of the enactment of the Health & Social Care Act, from June the Board of Directors' meetings would be held in public. Some more confidential items would need to be reserved for a private Part 2, but the great majority of items would fall under Part 1.

It had been agreed that the May Board meeting would be used to prepare for the June meeting. During today's meeting each item would be reviewed to consider whether any element should fall within Part 2 of a future meeting. The only reasons for an item falling into Part 2 would be either when it was commercially sensitive, or if an item related to an individual and such details had to remain confidential.

STRATEGY

74/12 **QUALITY STRATEGY PROGRESS & IMPLEMENTATION**

Sue Jones provided the Board with a major update on the progress in implementing the Quality Strategy. She also set the context of current care issues. For example, the Board was informed that a snapshot

survey of all inpatients yesterday had identified 36 patients with dementia, which was over 10% of all patients in the hospital.

The Board discussed the Trust's position in relation to a national media story on patients being discharged during the night. The Board was informed that it is not the Trust's practice to discharge inpatients at night. The Trust's PAS system does not record time of discharge so the FOI request could not be responded to fully, however the Board was concerned that it should be established that no patients were in fact discharged inappropriately during the night. The Board requested a paper for the next meeting providing a picture of current policy and practice. The Board also recognised the importance of building this perspective into the urgent care pathway work in relation to the development of the Yeovil Health Campus. This needed to be reflected in the workforce balance, particularly as the Trust makes progress with its hospital to healthcare strategy. **SJ**

The Board reviewed progress on a number of key performance indicators developed through the South West Patient Safety initiative. It also heard of the focus on patient experience, the progress that has been made, and the work planned for the coming year. The recent 'Living with Cancer' conference in particular had been a great success, with 140 people attending, the great majority from patients, carers and the public.

Sue Jones also emphasised that in addition to the Quality Strategy's objectives, the opportunities presented by the 2012-13 CQUINs must be grasped.

The Board welcomed the progress to date but discussed the extent to which the progress had been directly linked to the outcomes set out in the strategy document. It was felt that the actual achievements had been understated and that a clearer communications approach was needed to provide reassurance to the public. It was noted that the Quality Account was a significant opportunity to publicise the Trust's quality improvements. It was agreed that the draft Quality Account would be circulated to the Board. **SJ**

75/12 **SERVICE TRANSFORMATION**

1. Service Transformation & Milestones
Jeremy Martin provided an overview of the progress to date and some particular areas of early achievement. The comprehensive dashboard is in draft form but will be ready for the next Board meeting. The Chairman urged that boldness be adopted. The Board discussed the potential value of having key contributors attend the Board to talk about their work.

The Board recognised the need to close the existing gap in levels of savings identified. Without the dashboard this is difficult to establish and for the time being will remain a concern.

2. Procurement Update
The Board was informed of encouraging early progress on improving the Trust's approach to procurement and securing best value for

money.

3. Chairman's Update
REDACTED DUE TO COMMERCIAL SENSITIVITY

4. Health Campus and Car Park Report
REDACTED DUE TO COMMERCIAL SENSITIVITY
whether there was an opportunity to take a county-wide strategic approach to provision of some of the care services envisaged for the campus, or whether there were other opportunities on a more limited scale to co-ordinate provision of services.

76/12 **OPHTHALMOLOGY SERVICE**
REDACTED DUE TO COMMERCIAL SENSITIVITY
The Board also recognised that the same approach might be fruitful for at least some of the other visiting services.

77/12 **TRUST STRATEGY REVIEW**
The Board APPROVED the revised strategy overview with some amendments from the Board which will be incorporated.

The updated document will be incorporated into the Annual Plan for Monitor and submitted to the Governors. It was also agreed that GPs should have the document shared with them as a working draft.

The Board also agreed that it was important to communicate this vision to the public. **JM**

78/12 **MINUTES OF THE PREVIOUS MEETING**
The Board APPROVED the minutes of the meetings held on 14 March 2012.

79/12 **ACTION SHEET**
The Board NOTED the action sheet.

32/12 - It was confirmed that the requirement for theatre investment had been modified. It would now explore the opportunity to increase theatre capacity to release more time for private work. The Board asked that a date be set for providing a report on this work. **JHig**

62/12 – Regarding SCBU, local trusts' facilities have been reviewed and the feedback is that the current plans will leave YDH well placed to provide high quality care into the future. Specialist commissioners have confirmed that option B is acceptable.

80/12 **MATTERS ARISING**
There were no matters arising.

81/12 **CHIEF EXECUTIVE'S BRIEFING**
The Board NOTED the briefing. The Trust achieved all the targets for a green governance performance by the end of March. The significant amount of hard work by a large number of people was recognised, but the narrow margin by which the targets had been achieved was a scenario must not be repeated. The Trust also achieved a surplus of £1m.

Contract finalisation had taken place with NHS Somerset and further clarity had been provided on the conditions for achievement of CQUIN targets. In order to receive CQUIN payments RTT performance must be delivered together with other key performance metrics within the contract. Failure to deliver the agreed RTT will result in 50% of CQUIN not being paid. Failure to deliver the other contract performance metrics would require a recovery plan and payment will be withheld if the recovery plan is not delivered.

The Board noted that there was a threat of industrial action in the coming weeks and in particular the potential impact of action by medical staff. Unison is also balloting for strike action. Alison Rayner will continue to liaise with local staff side representatives.

82/12 **DELIEVERING SUSTAINABLE COST IMPROVEMENT PROGRAMMES**

The Board NOTED the paper and in particular considered the importance of communicating to the wider organisation the very significant nature of the transformation programme.

The Board agreed that a follow-up report was needed and how this would be managed would be agreed outside the meeting.

81/12 **SOUTH WEST PATHOLOGY PARTNERSHIP BOARD**

The Board discussed the paper, which would also be considered by the Taunton & Somerset Board. REDACTED DUE TO COMMERCIAL SENSITIVITY

After careful discussion the Board AGREED to proceed with the service, adopting Plan B, but ensuring staff transfers were co-ordinated between the two trusts.

ITEMS FOR APPROVAL

82/12 **INVESTMENT INTO THE EMERGENCY DEPARTMENT**

Jonathan Higman introduced the paper, which the Board considered. It was emphasised that the investment requested should be dependent on achievement of the changes in working practice that the paper also sets out. The consequence should be a tangible improvement in 6-9 months' time as a result of the investment.

The Board discussed the paper and it was confirmed that all the recommendations had the support of the ECIST team. The Board asked that the Emergency Department confirm that they are fully supportive of this approach as the solution and are also supportive of the requirement to deliver the improved performance identified. The Board asked Mr Higman to convey to the department that it will be monitoring the progress and will expect to see results within the 6-9 month period.

The Board discussion also recognised that leadership within the department had a significant role to play in securing the required improvement.

The Board AGREED the investment and also agreed that there should be discernible quality improvements in the service very rapidly. Mr Higman will develop some suitable metrics and report back at the next meeting. The requirement for a risk budget would also be reviewed. **JHig**

83/12 **YDH ARTS STRATEGY 2012-15**

The paper was introduced by Robert Steele. The arts input provides a significant benefit for patients, though much of the work that is done takes place in the background.

The Board considered the importance of ensuring there were proper organisational arrangements for the management of this strategy.

The Board APPROVED the strategy.

PERFORMANCE, RISK & ASSURANCE

84/12 **PERFORMANCE DASHBOARD AND COMMENTARY**

The Board NOTED the principal performance issues. The Quarter 4 return for Monitor will show Green for governance and a Financial Risk Rating of 3.

The Board congratulated the Trust staff on achieving such a good outcome.

85/12 **MONTHLY PERFORMANCE**

The Board NOTED the monthly performance pack and risk reports. The Board considered some key issues from the following papers:

1. Director of Nursing & Clinical Governance Risk Report

Sue Jones reported on a county-wide inspection on looked after children by the CQC and Ofsted. The Trust is undertaking a lot of work collating information in preparation for this. The Board was also alerted to changing requirements for Safeguarding Children training. The inspection begins on 29 April for two weeks.

The Board also noted the 'never event' relating to a retained screw.

2. Clinical Governance Report

3. Director of Operations Risk Report

4. Service Delivery Report

The Board was alerted to the importance of consistent delivery of the ED four hour standard, the 90% stroke admission standard and the risk relating to non-admitted patients for the RTT standard. The Board was also informed of a number of steps that are being taken to secure performance.

5. Clinical Governance Assurance Committee Report

The Board noted with concern the lack of a service-level agreement with Taunton & Somerset regarding oncology, but Jonathan Higman assured the Board that this was being put in place.

6. Director of Finance Risk Report

7. Finance Report

It was confirmed that the unaudited surplus was £993k.

8. Director of Human Resources Risk Report

9. Human Resources Report

The Board was informed that the sickness absence position may be deteriorating, which could be a consequence of staff being under greater strain. In addition, the recruitment and retention premium for Facilities staff has been reduced nationally and this has had an understandable impact on staff. It is important that pay decisions are made consistently and equitably. There is also continuing uncertainty on the national approach to clinical excellence awards.

10. Director of Estates & Facilities Risk Report
11. Estates & Facilities Report
12. Director of Planning & Performance Risk Report
13. Planning & Performance Report

86/12 **BOARD OF GOVERNORS' MEETING**

The feedback report from the last Board of Governors' meeting was NOTED.

87/12 **APPOINTMENT OF NON-EXECUTIVE DIRECTORS**

The Board NOTED the paper on NED appointments.

The Board APPROVED the appointment of one additional NED for a one year period from 1 June 2012 to 31 May 2013.

88/12 **PRIVATE PATIENT MARKETING GROUP**

The Chairman reported that Alexander Russell has agreed to continue to chair this group. This was AGREED by the Board.

89/12 **BOARD OF DIRECTORS' MEETING DATES 2012-13**

The dates were NOTED.

90/12 **ANY OTHER BUSINESS**

1. Freedom of Information

In future, the Board will receive a note of all FOI requests. **SC**

2. Car Park publicity

The Board agreed that its commitment to constructing a new car park could be communicated to the rest of the organisation.

91/12 **DATE OF NEXT MEETING**

The next meeting will be held on Wednesday 16 May 2012.

Yeovil District Hospital NHS
NHS Foundation Trust

Report to: **Board of Directors**

Report from: **Deputy Chief Executive**

Subject: **Chief Executive's Briefing**

Date: **16 May, 2012**

APPENDIX 3
BOARD OF DIRECTORS
16 MAY, 2012

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1. Strategy

1.1 Yeovil Health Campus (Cheverton Development)

In order to take forward the Yeovil Health Campus Project, work streams are being set up to review care pathways across primary and secondary care. The Somerset Commissioning Group has outlined a commitment to working in partnership with the Trust on this development further meetings are planned with the Somerset Commissioning Group in order to discuss potential future arrangements. Both NHS Somerset and the Somerset Clinical Commissioning Group have invited the Trust to present this work at their next Board meetings.

1.2 Service Transformation

The Service Transformation programme, aimed at improving quality and patient experience and making our resources go further, is taking shape. Over 50 work streams are now in place, co-ordinated by the Programme Office. 21 project managers, seconded part-time from clinical and non-clinical roles within the Trust, have been allocated to support key projects, such as the Health Campus, the urgent care pathway redesign, and the review of clinical administration pathways.

As well as improving quality, the programme has a financial target of generating £4.5M of savings or additional income this year. So far £3.5M has been identified, with the remaining £1M being addressed through better procurement, and through projects where the benefits are still being scoped.

1.3 IT Strategy

A key element of the Transformation Programme is a £2.5M investment in new clinical systems to support clinical care and more efficient ways of working. Procurement will take place during the remainder of 2012/13, with a view to implementation from 2013/14 onwards. This includes a phased moved to an electronic patient record, with electronic prescribing, a new maternity system, the ability to share and receive information from community systems, and the ability for clinicians to view all of the information about a patient within a single view.

The procurement model is currently being finalised and is the subject of a separate paper.

2. **Somerset Clinical Commissioning Group** (CCG)

Somerset CCG has confirmed that they are applying to be authorised as a CCG in Wave 1 of the national programme. It they do achieve authorisation within Wave 1 they will become a legal entity from April 2013. The timetable for this authorisation process is as follows:

- 360° stakeholder survey May/June12
- Submit application – July 2012
- National Commissioning Board Site Visit – Summer 2012
- Final Decision made – October 2012

Somerset CCG have confirmed that their Shadow Governing Body during 2012/13 will be made up as follows:

- GP Chair and GP vice-chair
- 2 other GP members
- Specialist Doctor
- Registered Nurse
- Director of Public Health
- Managing Director
- Chief Finance and Performance Officer
- 2 voting Lay members and 1 non-voting lay member
- 3 further non-voting members covering the following roles: Director of Clinical Commissioning Development; Director of Patient Engagement and Strategy; LMC representative.

Somerset CCG has not confirmed the appointments to these posts as yet.

3. **NHS South of England – South West Chief Executives' Meeting 5 May 2012**

Updates were provided on the following areas of national work:

- **Medical Revalidation.** Board of Directors are responsible for ensuring that systems are in place to support the Responsible Office (i.e. The Medical Director) to undertake revalidation by December 2012. This will include ensuring that robust appraisal systems that are adequately resourced with appropriately trained and supported appraisers are in place.

- **Net Promoter Scores.** A system is being developed that will pull together areas of feedback from service users to allow organisations to understand if users would recommend their services to others. This is commonly used in industry and is being developed for the NHS.

4. **Southwest Pathology Services**

The transfer of the Pathology Service to the Southwest Pathology Service Joint Venture has been delayed due to an unresolved issue REDACTED DUE TO COMMERCIAL SENSITIVITY Staff are being kept fully informed of this situation.

5. **Assurance Issues**

The Care Quality Commission is currently undertaking an inspection of safeguarding and the health of looked after children across Somerset. Feedback will be provided back to the Trust at a later stage.

6. **Operational Issues**

The Trust achieved all of its performance requirements to secure a green governance rating and a financial risk rating of 3 from Monitor. All of our financial targets were achieved and a surplus of £1million was delivered to invest back into our buildings and equipment.

Delivering these statutory requirements is essential to the future viability of the hospital. At the same time we are committed to providing high quality services and a positive experience to all of our patients. It is therefore very pleasing to see the achievements we have made against our commitment to improving quality as set out in the Quality Strategy. We have made noticeable improvements in a number of areas including reducing patient falls, improving the timely assessment for venous thrombo-embolisms, enhancing care for dementia patients and reducing our mortality rates. There remain some areas where our systems are not working as well as they should and we are reviewing these through the Service Transformation Programme. I would like to take this opportunity to thank all of our staff for the part they have played in delivering this high level of performance which has enabled us to continue to improve the quality of services we provide here at Yeovil District Hospital.

7. **Workforce Issues**

- **Radiology Consultant -** Dr Emma Jackson has been appointed as a Radiology Consultant with a speciality interest in Breast.

- **Potential Industrial Action -** The BMA are currently balloting members regarding potential industrial action.

- **Chief Executive -** Paul Mears, Chief Executive commenced on the 8 May 2012 and I would like to take this opportunity to welcome Paul to Yeovil District Hospital where we are very much looking forward to working with him.

Libby Walters
May 2012

Annex 1

STRATEGIC OBJECTIVE	MEASURE	LEAD DIRECTOR	TARGET	THRESHOLDS	1011 YTD	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	1112 YTD
Personal, high quality and safe care																		
To reduce HSMR year on year by 2.5%	Rolling 12 month HSMR	Medical Director	90%	<= 100 - Green >100 but lower confidence limit below 100 - Amber Lower confidence limit above 100 - Red	105.5	103.2	104.4	117.4	114.5	110.1	108.4	106.3	107.1	103.9	100.4			100.4
To ensure that the risk of VTE is minimised	Percentage of patients who need it receiving appropriate VTE (chemical) prophylaxis	Director of Nursing & Clinical Governance	95%	>=95% = Green 85 - <95% = Amber <85% = Red	86%	89%		91%	89%									N/A
	Percentage of patients with completed VTE risk assessment - PAS data submitted to Unify	Director of Nursing & Clinical Governance	90%	>=90% = Green <90% = Red	68.6%	67.8%	64.8%	66.2%	70.4%	69.7%	75.5%	76.2%	68.2%	69.7%	71.0%	89.1%	91.1%	76.5%
To maintain our infection rates at the level of the best 25% of Trusts	Number of 48 hour + MRSA Bacteraemias cases (Rate per 1000 beddays)	Director of Nursing & Clinical Governance	1 per year	0 = Green >=1 = Red	1 (0.01)	0	0	0	0	0	0	0	0	1	1	0	0	2
	Number of 72 hour + Clostridium Difficile cases	Director of Nursing & Clinical Governance	29 per year	0 - <=2 per month = Green 3 = Amber >=4 per month = Red	48	4	1	4	3	1	0	2	2	0	2	2	2	23
	Percentage handwashing compliance	Director of Nursing & Clinical Governance	95%	>=95% = Green 85 - <95% = Amber <85% = Red	92%	87%	89.0%	88.8%	90.6%	92.0%	94.0%	90.0%	94.0%	88.0%	95.0%	90.4%	89.7%	90.5%
Continue to reduce falls by 10% on 10/11 outturn	Number of falls (Rate per 1000 bed days)	Director of Nursing & Clinical Governance	737 (10% decrease on previous year)	<=62 = Green >62 = Red	893 (8.2)	82 (9.4)	71 (7.8)	70 (8.0)	54 (6.3)	92(11.3)	62 (7.9)	49 (6.4)	71 (8.6)	94 (12.1)	60 (6.8)	75 (8.5)		780(8.4)
To ensure that stroke patients receive quick, high quality interventions and appropriate care	Percentage of stroke patients spending 90% of time on stroke ward	Director of Nursing & Clinical Governance	80%	>=80% = Green 60 - <80% = Amber <60% = Red	58.5%	84.4%	62.8%	60.0%	75.9%	78.3%	100.0%	78.3%	86.4%	57.1%	65.0%	81.8%	81.3%	74.7%
	Percentage of high risk TIAs treated within 24 hours	Director of Nursing & Clinical Governance	60%	>=60% = Green 50 - <60% = Amber <50% = Red	56.2%	100.0%	83.3%	61.9%	50.0%	85.7%	83.3%	88.9%	77.8%	60.0%	50.0%	71.4%	88.9%	74.4%
To provide a high quality pathway through the hospital for emergency and elective patients	30day readmission rate -Total readmissions	Director of Operations	<10%	<10% = Green >=10% = Red	5.5% (1.5%)	13.1%	14.2%	13.1%	14.6%	13.4%	16.3%	15.3%	12.6%	13.0%	13.0%	14.9%	13.9%	14.0%
	Delayed transfers of care	Director of Nursing	<=3.5%	<3.5% = Green 3.5 - 5.0% = Amber >5.0% = Red	4.5%	0.3%	2.0%	1.3%	3.0%	3.9%	1.0%	0.7%	0.7%	0.0%	0.0%	3.3%	0.0%	1.4%
	Cancelled Ops - <28day readmission guarantee breaches	Director of Operations	5%	<=5% = Green 5 - 15% = Amber >15% = Red	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
To ensure that privacy and dignity for all patients improves, with an emphasis on the needs of patients with dementia	Implement Dementia Action Plan	Director of Nursing & Clinical Governance		On plan = Green Within one month = Amber Not within plan = Red														N/A
To develop a patient experience strategy based on comprehensive patient feedback on our services	Sample size for exit questionnaires	Director of Nursing & Clinical Governance	Double sample size	within 10% of prev. month = Green 10 - 15% = Amber <15% = Red	77	75	85	85	91	95	127	107	133	69	62	56	76	1061
To ensure that 95% of patients are satisfied or very satisfied with their experience of the hospital	Percentage of patients rating their care as very good or excellent	Director of Nursing & Clinical Governance	95%	>=95% = Green 85%-<95% = Amber <85% = Red	99%	96%	96%	92%	96%	96%	93%	93%	99%	86%	96%	96%	93%	94%
Strong, sustainable services, meeting local needs																		
To achieve 18 weeks consistently in all specialties	18 week wait - Admitted Pathways - 95th Percentile (% achievement)	Director of Operations	23wks (90%)	<=23wks = Green 23wks - 27.7wks = Amber >27.7wks = Red	93.2%	20.3wks (93.5%)	19.6wks (94.4%)	22.3wks (91.9%)	22.4wks (92.1%)	20.4wks (93.9%)	22.9wks (92.3%)	23.0wks (91.4%)	22.0wks (91.9%)	20.9wks (93.2%)	22.8wks (90.8%)	22.1wks (90.8%)	22.5wks (92.2%)	22.1wks (92.1%)
	18 week wait - Non-admitted Pathways - 95th Percentile (% achievement)	Director of Operations	18.3wks (95%)	<=18.3wks = Green >18.3wks = Red	96.7%	16.8wks (96.0%)	16.0wks (97.3%)	17.8wks (95.4%)	17.6wks (96.0%)	17.5wks (96.1%)	17.0wks (96.5%)	16.8wks (96.6%)	17.7wks (95.5%)	17.8wks (95.2%)	17.9wks (95.1%)	17.8wks (95.3%)	15.5wks (96.7%)	17.4wks (96.0%)
	18 week wait - Incomplete Pathways - 95th Percentile (% achievement)	Director of Operations	28wks	<=28wks = Green 28wks - 36wks = Amber >36wks = Red	84.6%	22.4wks (88.4%)	23.7wks (86.6%)	23.7wks (81.3%)	23.7wks (81.3%)	26.4wks (80.9%)	26.3wks (78.9%)	24.9wks (78.5%)	26.5wks (80.5%)	25.9wks (82.2%)	20.5wks (93.3%)	18.0wks (95.0%)	18.5wks (94.6%)	24.5wks (84.2%)
	TOTAL OP Waiting List size	Director of Operations	Size @ March 10	<= 2700 = Green 2701 - 2800 = Amber >2800 = Red	2779	2794	2778	2854	2985	2835	2754	2670	2634	2630	2577	2661	2693	N/A
	No. of >5wk waiters on OP Waiting List	Director of Operations	No. @ March 10	<= 700 = Green 701 - 800 = Amber >800 = Red	832	1092	1046	1168	1176	1132	978	881	832	1017	718	709	811	N/A
	TOTAL IP/DC Waiting List size	Director of Operations	Size @ March 10	<= 2000 = Green 2100 - 2000 = Amber >2100 = Red	1574	1633	1674	1513	1519	1514	1506	1584	1557	1643	1644	1612	1610	N/A
To ensure that patients are seen in a timely way in A&E	4 hour performance (Trust only)	Director of Operations	95%	>=95% = Green 94%-<95% = Amber <94% = Red	96.4%	94.0%	94.7%	96.4%	96.1%	97.2%	97.6%	97.5%	95.9%	96.7%	94.3%	92.9%	97.8%	95.9%
	Total time of 4 hours in A&E (95th Percentile)	Director of Operations	<=4hrs	>4hrs = Red <=4hrs = Green	N/A	4:32hrs	4:15hrs	4:00hrs	3:59hrs	3:59hrs	3:58hrs	3:57hrs	3:59 hrs	3:59 hrs	4:28hrs	4:53hrs	3:58 hrs	4:00 hrs
	Time to Initial Assessment (95th Percentile)	Director of Operations	<=15mins	>15mins = Red <=15mins = Green	N/A	42mins	38mins	30mins	44mins	22mins	28mins	24mins	27 mins	24mins	25mins	30mins	24mins	30mins
	Time to Treatment Decision (median)	Director of Operations	<=60mins	>60mins = Red <=60mins = Green	N/A	1:16hrs	1:09hrs	1:13hrs	1:14hrs	1:08hrs	56mins	50mins	53 mins	45 mins	56mins	1:08 hrs	58mins	1:02 hrs
	Unplanned reattendance rate	Director of Operations	<=5%	>5% = Red <=5% = Green	N/A	3.4%	3.7%	3.5%	3.1%	3.5%	3.5%	3.7%	2.9%	3.8%	2.9%	3.7%	3.8%	3.4%
	Left without being seen rate	Director of Operations	<=5%	>5% = Red <=5% = Green	N/A	2.6%	2.0%	2.7%	2.8%	3.1%	2.2%	1.4%	1.4%	1.8%	2.0%	1.8%	2.1%	2.2%
To ensure that cancer patients receive quick diagnosis and treatment	2 weeks from urgent suspect cancer GP referral to first outpatient appointment	Director of Operations	93%	>=93% = Green 88 - <93% = Amber <88% = Red	94.9%	93.0%	90.4%	93.2%	94.1%	94.9%	93.4%	92.0%	93.9%	93.9%	93.4%	96.1%	93.6%	93.5%
	2 weeks from Urgent GP referral to first outpatient appointment (Symptomatic Breast Patients)	Director of Operations	93%	>=93% = Green 88 - <93% = Amber <88% = Red	93.9%	89.4%	94.1%	97.8%	95.7%	94.4%	94.7%	94.4%	96.4%	100.0%	95.7%	98.1%	97.8%	95.8%
	31 days from decision to treat to start of 1st treatment extended to all cancers	Director of Operations	96%	>=96% = Green 91 - <96% = Amber <91% = Red	98.7%	100.0%	98.2%	98.2%	97.7%	98.5%	100.0%	98.0%	100.0%	100.0%	98.6%	96.5%	98.5%	98.7%
	31 days from decision to treat to start of treatment for subsequent DRUG treatment	Director of Operations	98%	>=98% = Green 93 - <98% = Amber <93% = Red	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	31 days from decision to treat to start of treatment for subsequent SURGICAL treatment	Director of Operations	94%	>=94% = Green 90 - <94% = Amber <90% = Red	99.5%	100.0%	94.1%	100.0%	100.0%	93.3%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%
	62 days from all referrals to treatment for all cancers	Director of Operations	85%	>=85% = Green 80 - <85% = Amber <80% = Red	93.7%	93.4%	85.5%	87.7%	85.5%	95.9%	88.8%	87.5%	93.0%	94.1%	95.9%	89.7%	90.1%	91.0%
	62 days from Consultant Screening to treatment for all cancers	Director of Operations	90%	>=90% = Green 85 - <90% = Amber <85% = Red	57.9%	N/A	100.0%	50.0%	100.0%	100.0%	N/A	100.0%	N/A	50.0%	100.0%	100.0%	90.9%	87.9%
	62 days from Consultant Upgrade to treatment for all cancers	Director of Operations	90%	>=90% = Green 85 - <90% = Amber <85% = Red	91.6%	88.2%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%	98.2%

Annex 1

STRATEGIC OBJECTIVE	MEASURE	LEAD DIRECTOR	TARGET	THRESHOLDS	1011 YTD	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	1112 YTD
Our staff are our greatest strength																		
To provide excellent support and development for our staff	Percentage of staff appraised within last 12 months (rolling year)	Director of Human Resources	80%	>80% = Green 65 - 80% = Amber <65% = Red	70%	74%	74%	73%	72%	74%	72%	71%	69%	70%	73%	72%	73%	73%
	Percentage of staff attending mandatory training within last 12 months (rolling year)	Director of Human Resources	85%	>85% = Green 70 - 85% = Amber <70% = Red	68%	67%	66%	65%	65%	63%	65%	64%	66%	64%	65%	66%	67%	67%
To provide management development in those in leadership positions	Number of Human Resources indicators achieved	Director of Human Resources	7	>4 = Green 3 - 4 = Amber <3 = Red	4	3	4	3	4	3	4	4	4	4	4	4	4	4
To develop a strategic workforce plan and succession planning process linked to business plans	Vacancy rate	Director of Human Resources	TBC		3.7%	4.0%	3.7%	4.0%	3.1%	5.0%	4.4%	4.2%	4.1%	4.0%	3.7%	3.4%	3.8%	3.8%
	Total pay costs (Cumulative)	Director of Human Resources	TBC		N/A	£5.9M	£11.9M	£17.9M	£23.8M	£29.8M	£35.8M	£41.7M	£47.7M	£53.5M	£59.5M	£65.7M	£71.5M	£71.5M
	Temporary staff cost (Cumulative)	Director of Human Resources	TBC		£2,776k	£165k	£322k	£490k	£655k	£867k	£1,030k	£1,126k	£1,260k	£1,386k	£1,538k	£1,720k	£1,967	£1,967k
A valued partner in the local health service																		
To maintain market share	GP Referrals Total numbers (% against plan)	Director of Operations	0%	0 - <5% from plan = Green 5 - 10% away from plan = Amber >10% from plan = Red	29883	2173 (-13.6%)	2466 (1.3%)	2467 (-9.1%)	2345 (-12.5%)	2348 (5.1%)	2477 (-2.8%)	2334 (-6.7%)	2457 (3.1%)	2054 (2.1%)	2484 (5.9%)	2524 (1.9%)	2539 (-8.2%)	28676 (-3.2%)
To develop an effective Commercial Strategy	Annual income earned from new sources	Director of Finance										£46.7k	£50.9k	£48.8k	£40.1k	£40.4k	£40.7k	
Managing our money wisely																		
To increase the efficiency of our services by delivering a cost improvement programme of £4.7 million	% of CIP plans in place	Director of Finance	100%	0 - <5% from plan = Green 5 - 10% away from plan = Amber >10% from plan = Red	100%	88%	74%	74%	80%	81%	86%	91%	93%	95%	96.0%	97.0%	100.0%	100.0%
Achieve a financial risk rating of 3	CIP Total Savings (non-recurrent %)	Director of Finance	100%	0 - 5% > plan = Green 5 -10% away from plan = Amber 10% <from plan = Red	100% (14%)	94% (19%)	103% (16%)	113% (10%)	118% (5%)	115% (4%)	123% (17%)	113% (15%)	108% (17%)	106% (11%)	104% (4%)	99% (6%)	100% (12%)	100% (12%)
	Financial risk rating	Director of Finance	3	> 3 = Green 2.5 - 3 = Amber <2.5 = Red	3.6	3.2	2.7	2.7	3.4	2.7	2.7	3.2	3.2	2.8	3.0	3.3	3.2	3.2
	RoA (YTD)	Director of Finance	5.2%	>=5.2% = Green 4.0 - 5.1% = Amber <4.0% = Red	5.0%	4.3%	3.2%	3.1%	3.2%	3.2%	3.3%	3.7%	3.8%	3.2%	3.7%	3.5%	3.9%	3.9%
	Liquidity Ratio	Director of Finance	25	>25 = Green 15-25 = Amber <15 = Red	26.9	24.4	22.4	23.2	25.6	23.5	23.4	25.3	25.5	24.8	24.7	25.4	22.4	22.4
	PbR Income performance (£) YTD	Director of Finance	0	>0 = Green -£150,000k - 0 = Amber <-£150,000k = Red	-1,062,000		-£186,000	-£96,000	-£280,000	£145,000	-£77,000	-£230,000	£335,000	£153,000	£522,000	£715,000	-£170,000	-£170,000
To reduce readmission rates	PBR 30 day Readmission rate - Post-elective	Director of Operations	TBC		N/A	2.4%	2.9%	2.7%	3.0%	2.5%	3.2%	4.2%	1.8%	3.0%	3.0%	3.5%	3.0%	2.9%
	PBR 30 day Readmission rate - Post-emergency	Director of Operations	TBC		N/A	10.7%	11.3%	10.4%	11.7%	10.9%	13.1%	11.1%	10.8%	9.9%	10.0%	11.3%	10.9%	11.0%
To deliver a surplus of £0.3M for investment in our buildings	I&E Surplus (YTD)	Director of Finance	1%	>1% = Green 0.0 - 1.0% = Amber <0.0% = Red	1.0%	1.2%	-1.4%	0.4%	1.6%	0.2%	0.5%	0.9%	0.3%	0.2%	0.6%	0.8%	0.7%	0.7%
	I&E position - variance from plan (YTD)	Director of Finance	On plan			£4,000	-£68,000	-£159,000	-£134,000	-£95,000	-£63,000	-£61,000	-£60,000	£32,000	£85,000	£113,000	£718,000	£718,000
	EBITDA (% of Plan Achieved)	Director of Finance	100%	>100% from plan = Green 85 - 99% = Amber <85% = Red	87.7%	102.6%	89.9%	89.4%	94.7%	94.3%	92.0%	99.1%	99.2%	102.2%	103.0%	103.4%	115.6%	115.6%
	EBITDA margin %	Director of Finance	5.9%	>5.9% = Green 4.0 - 5.8% = Amber <4.0% = Red	5.3%	5.9%	3.3%	4.9%	6.1%	4.7%	5.0%	5.5%	5.0%	5.0%	5.2%	5.1%	5.5%	5.5%
Infrastructure that supports delivery																		
To open the refurbished MacMillan Unit	Project progress against plan and budget	Director of Estates & Facilities		On plan = Green Within one month = Amber Not within plan = Red								Unit open	N/A	N/A	N/A	N/A	N/A	
IT strategy	Project progress against plan and budget	Director of Planning and Performance		On plan = Green Within one month = Amber Not within plan = Red	N/A													
Estates strategy	Project progress against plan and budget	Director of Estates & Facilities		On plan = Green Within one month = Amber Not within plan = Red	N/A													

Annex 1

Dr Foster rebased HSMR benchmarks in June leading to a shift in expected values.

New audit data to be taken from Nursing Documentation starting from Oct 11. Reporting start delayed until Nov 11.

Reported a month in lieu.

Data unavailable for Mar.

NOTE: changed from 28 to 30 day and matched to new 2011/12 Technical Guidance

2011/12 - monthly SITREP snapshot (based on last Thursday in reporting period)

Annex 1

Referrals plan has been adjusted to account for the removal of the Pain Service.

Yeovil District Hospital NHS
NHS Foundation Trust

To: **Board of Directors**

From: **Director of Nursing & Clinical Governance**

Subject: Dementia Progress Report

Date: 16 May 2012

APPENDIX 4
BOARD OF DIRECTORS
16 MAY 2012

1. INTRODUCTION

1.1 The national dementia strategy[1] published in 2009 set standards for the improvement of diagnostics, treatment and support in the community, whilst also setting standards for improvement for patients admitted to hospital who also happen to have dementia.

1.2 In 2009 there were an estimated 700,000 people in the UK with dementia, costing the UK economy £17 billion a year projections in the strategy are that over the next 30 years, the number of people with dementia in the UK will double to 1.4 million, with the costs trebling to over £50 billion a year.

1.3 Dementia can occur at any age, although the numbers rise more dramatically with older people, there are significant challenges caring for patients with dementia in the acute care setting. With no short term memory and limited cognitive ability an unfamiliar hospital environment can be a very frightening place.

1.4 The Trust has high numbers of older patients, with patients over 85 years of age becoming the norm. The numbers of patients with a known diagnosis of dementia afre counted daily on SwiftPlus. In the last month there were 36 inpatients with dementia, for some wards, this amounted to more than a full bay. Some of these patients require specialing to keep them safe.

1.5 The South West Regions dementia standards and an approach to peer review has been extremely supportive and effective in driving improvement. The model of peer review has been one of support and challenge.

2. PEER REVIEW

2.1 The Trust peer review November 2011, confirmed the progress made against the dementia level 1 standards and in particular noted strong and effective leadership, an innovative training programme now adopted across the region, and provided positive feedback for the champions

2.3 The Trust recognised the need to work on occupation for patients and the action plan following the peer review remains work in progress, led by Jo Ryan, Associate Director of Nursing and delivered by the Dementia steering group that includes volunteers and champions

[1] DH (2009) Living Well with Dementia:A national dementia strategy

3. PATIENT AND CARER EXPERIENCE

3.3 Governors with experience in facilitation supported the use of Experience Based Design methodology to bring to staff the views of a focus group of carers. This work concludes this month with a review meeting of both the staff and carer focus group.

3.4 The actions arising out of this approach are being addressed by the dementia steering group.

3.5 Carers awareness training developed by the patients association, carers UK and Trust volunteers has been well received, is now being rolled out, and is being presented in a workshop at the South of England Nursing Conference on Friday 11 May.

3.4 Dementia befrienders have been recruited.

3.5 A modified 'YourCare' questionnaire for patients with dementia has been developed. A PPI member who is also a carer administers this questionnaire on one ward. This work builds on the Trusts quality strategy and the aim to increase the feedback received from a wider range of patients.

4. MANAGING CHALLENGING BEHAVIOUR

4.1 The national staff survey results across Somerset have recorded a rise in the number of staff who have experienced physical violence in the last year. This finding also links to the national patient survey and the number of patients who have felt threatened by other patients or visitors. This finding across Somerset is not about Saturday night violence in the Emergency Department but reflects the growing number of patients with dementia.

4.2 The Trust has implemented a wandering patients policy, this policy sets out to ensure that patients who may have either delirium or dementia can wander safely rather than become more frightened or confused if restrained.

4.3 Some patients with dementia can become aggressive, the dementia work has ensured that staff are better equipped to manage challenging behaviour and will call in other agencies as needed.

4.4 The peer review process highlighted the limits of the older persons mental health team and this limitation will need to remain a focus of partnership and commissioning discussions.

5. DEMENTIA CQUINS

5.1 The national cQUIN for dementia requires Trusts to ask all over 75's 'the dementia screening question', and to upload results onto Unify. For patients with a positive screen referral should then be made to a specialist or back to the general Practitioner for diagnosis.

5.2 The local cQUIN builds on the work completed last year in implementing the level 1 standards (Annex 1), and to implement the level 2 standards.

5.3 There is also a local cQUIN requiring Audit of patients on antipsychotic medication. This audit has already been presented to Clinical Governance Deleivery Group, the numbers of patients being prescribed antipsychotics for the first time in hospital amounted to 3 patients, and the prescription was within guidelines.

5.6 There is further work to do as a result of the audit to ensure patients who have been admitted already on antipsycotics trigger a review.

6. FUTURE PLANS

6.1 Performance metrics to include information about dementia at corporately and in Divisional dashboards.

6.2 Clinicians to develop practice with regard to the 3 'D's: Dementia, Delerium and Depression.

6.3 Build on the work of the dementia champions and continue the successful joint working with carers.

6.4 Continue to benchmark and share best practice across the SW Region.

6.5 Cross divisional work required to review how Care of the Elderly physicians can be used to the best effect to meet demand.

6.6 This year's nursing skill mix review to address the demand and need for 'specials' and how best to provide optimal patient care.

6.7 Work closely with Somerset Partnership Trust and commissioners to maximise clinical provision from the older persons mental health team.

The Board of Directors is asked to **DISCUSS** the progress made in meeting the needs of patients with dementia in the acute care setting.

South West Dementia Partnership

South West Hospital Standards in Dementia Care

Yeovil District Hospital NHS
NHS Foundation Trust

Annex 4: South West Hospital Standards in Dementia Care improvement plan template

March 2012 – Version 4

www.southwestdementiapartnership.org.uk/hospital-standards

Hospital Improvement Plan: Dementia Care in Hospital				
Hospital	**Yeovil District Hospital NHS Foundation Trust**			
Lead officer **Contact details**	**Jo Ryan** **Jo.ryan@ydh.nhs.uk**			
Date **Version**	**June, 2011** **1**	**August, 2011** **2**	**October, 2011** **3**	**March 2012** **4**
Reviewed by (include governance arrangements)	**Director of Nursing** **Clinical Governance General Manager** **Dementia Steering Group**			
Distributed to	**Dementia Steering Group** **Clinical Governance** **Alison Rowswell**			

To be submitted to NHS South West by 30 June 2011, c/o Claire.Evans@southwest.nhs.uk

Standard 1: Respect, dignity and appropriate care LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement Indicators	Status Tracking
1. A dementia ward champion role is in place on relevant wards, with specific responsibilities for implementation and audit of standards, training, coaching and mentoring.	100% of wards/clinical areas have Dementia Champions	D Mathewson	Ongoing	% of Dementia Champions	Green
	Support mechanism for Dementia Champions in place	D Mathewson	Ongoing	Audit Trail	Green
2. There is accessible laminated literature on the ward, including these standards and information about future planning, that can be understood by patients with early dementia and that can be used by their carers. There is a variety of literature for staff on the ward linking with training and development programmes within the hospital.	Source continuous supply of literature from Alzheimer's Society	J Ryan	Sep, 2011	Evidenced in practice	Green
	Top Tips laminated for display on wards	Champions	Sep, 2011	Evidenced in practice	Green
	Dementia Champions resource folder	Champions	Jun, 2011	Evidenced in practice	Green

Criteria	Actions	Lead	Deadline	Improvement Indicators	Status Tracking
3. The care plan is person-centred as evidenced by observation of staff interaction with patients. Patients' and carers' feedback demonstrates high levels of satisfaction with care. Minimum standard = 90%.	Person Centred Care Pilot on Ward 9a Dementia board in place.	P Harvey	Nov, 2011	Project evaluation	Green
	Roll out of "This Is Me" Adapted "This is Me" being printed. Evidence of use on 6a/9a/EAU	Champions	Mar, 2012	Evidenced in patients notes/or on admission from nursing homes	Green
4. Individualised and appropriate risk assessment will be undertaken and incorporated into the care plan involving relatives/carers in analysis. Minimum standard = 90%.	Roll out of "This Is Me". Carers questionnaire Trialled from August	Champions	Mar, 2012	Evidenced in patients notes/ evaluation of carers questionnaires	Green
	Completion of assessment training for clinicians in development with SOMPAR Dates being arranged with Dr N Warner for inclusion at Big Governance in January 2012 (deferred from October 2011)	J Ryan	Mar, 2012	Audit data/Attendance records	Amber

Standard 1: Respect, dignity and appropriate care

LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. Patient care is person centred informed by Dementia Care Mapping or similar methodology.	"This Is Me" tool used alongside West Abbey Nursing Home	Fiona Higginson/ Mandy Carney	Mar, 2012	Meetings with West Abbey/evidence of tool on admission from West Abbey	Blue
	Implementation of Well Being Tool	Champions	Mar, 2012	Audit data	Amber
2. Ward champion role training programme is delivered.	Maintain delivery of Dementia Champions training programme	D Matthewson	On-going	Attendance Records	Blue
3. The Trust Board regularly reviews serious and untoward incidents, falls, delayed discharges, and complaints associated with patients with a primary or secondary diagnosis of dementia.	Establish a system with safeguard to records falls/complaints etc. System established July 2011. Not yet being used in reports.	K Pardon	Mar, 2012	Safeguard Reports	Blue
	Reported incidents placed on Vulnerable Adults Board agenda when report established. Delay due to electronic system (Safeguard) not yet able to report specific dementia incidents.	J Ryan/ M Groves	Sept 2012	Minutes/Agenda	Blue

Standard 2. Agreed assessment, admission, discharge processes and needs specific care plans LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. Prior to a planned admission of a person with dementia or suspected cognitive impairment or on an emergency admission, the named carer/relative/friend is identified. S/he is provided with written information regarding the way in which s/he can support the patient. The names of key contacts are provided (e.g. consultant, lead ward nurse, liaison nurse / social worker). Minimum standard = 95%.	Implement a pre-assessment pathway for patients with dementia in partnership with carers	M Carney	Dec, 2011	Evidence of pathway in place. Carers questionnaire out-comes	Blue
	Implementation of "This Is Me" in pre-assessment	M Carney	Dec, 2011	Evidence in patients notes of "This Is Me"	Blue
2. Prior to a planned admission of a person with dementia suspected cognitive impairment, 'This is me' is completed. In an emergency admission an agreed modified version of 'This is me' is completed. This will inform an evidence- based multi-disciplinary care plan to be agreed within 24 hours with the patient and the main relative / carer / friend.	Develop a modified version of "This Is Me" for use in A&E in partnership with family and carers. Ensure this fits with the Trust version of "This is Me"	G Higgins/ J valentine	Mar, 2012	Evidence of revised "This Is Me" tool in patients notes	Blue

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
3. There is a system to detect and record cognitive impairment on the ward. All patients with suspected dementia receive a comprehensive assessment (unless there is evidence of this having been recently undertaken); where dementia is suspected but not yet diagnosed, this triggers a referral for assessment and differential diagnosis either in the hospital or in the community memory services. Minimum standard = 95%.	Implement enhanced training for clinicians around assessment for patients with dementia through SOMPAR Meeting held with SOMPAR leads (August) and an arrangement for attendance at Big Gov agreed.	J Ryan	Mar, 2012	Evidence of increased compliance on CT scans and the outcomes around referrals to the appropriate care agency. New CQUIN Target	**Green**
4. Carers receive all relevant information about the patient's assessment and are involved in discussion about further assessment. Carers understand that an assessment of their own needs can be arranged. Minimum standard = 95%.	Carers/relatives surgeries on Ward 9a pilot to identify carers needs commenced	P Harvey	Nov 11	Evaluation of pilot	**Green**

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
5. There is an agreed system in place across the hospital so that staff are aware of the person's dementia (visual identifier or marker in notes). Minimum standard = 100%.	System identified through PAS	J Ryan	dec 11	Evidenced through SwiftPlus	**Green**
	To be implemented across the Trust	Matrons/ Ward Sisters	dec 11	Evidenced through PAS	**Green**
6. Discharge is an actively managed process that begins within 24 hours of admission. Minimum standard = 95%.	Incorporate specific requirements into Discharge Policy. Achieved.	M Carney/ M Groves/ Discharge Facilitators	mar 12	Discharge Policy	**Green**
7. Accessible information about discharge is made available to patients and carers. This includes information in different languages where required. The information is made available at an early stage after admission. Minimum standard = 95%.	Incorporated into the Dementia Champions and Discharge Facilitators roles	J Ryan	Jun, 2011	Nursing records/ patients notes SITREP reports	**Green**

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
8. There is a named person who takes responsibility for discharge coordination for people with dementia, who has been trained in the ongoing needs of people with dementia and has experience of working with people with dementia and their carers.	Maintain the competency of Discharge Facilitators knowledge and skills around dementia	M Carney K Norris G Galway	Oct, 2011	SITREP/CHC Fast tracks All staff trained	Green
9. Discharge plans clearly document the patient's cognitive and functional status, treatment plan and community support plan. The community support plan is developed collaboratively with carers/families, and agencies providing support. Minimum standard = 95%.	Maintain the standard of SAP/CHC assessments	M Carney/ K Norris/ G Galway	Oct, 2011	SAPs/CHC data	Green
	Ensure completion of carers questionnaires	P Harvey	Nov, 2011	Outcome of carers questionnaires	Green
10. The hospital has access to intermediate care services which will support people with dementia where required and be available to avoid delayed hospital discharge.	Access to CHC Fast track	K Norris	On-going	Monthly reports	Green
	OT based in A&E to avoid hospital admission	S Edwards	On-going	Monthly reports	Green

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
11. The intermediate care services demonstrate effective diversion from acute care and care homes.	Maintain work with West Abbey to limit hospital admissions	M Carney	On-going	Monthly reports	Green

Standard 2. Agreed assessment, admission, discharge processes and needs specific care plans LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. Care pathways for patients with dementia, audit of patient notes and feedback from patient / carers have been reviewed at least annually, led by the senior clinical lead. Minimum standard = 100%.	Care pathway being developed across the region	Dementia Strategy Group	Mar, 2012	Care Pathway	Red
	Dementia care bundle under development. Draft 2 (August) to trial as soon as available	J Ryan/Fiona Higginson	Mar, 2012	Implementation of care bundle/ reduced length of stay	Blue
2. Discharge coordinator training programme is delivered.	Attendance by temporary Discharge Facilitators	M Carney	Aug, 2011	Attendance records	Green

Standard 3: Access to a specialist mental health liaison service LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. The hospital provides access to a mental health liaison service, which provides expertise in dementia for advice, screening, assessment, diagnosis, referral to and liaison with other services, and education and training for hospital staff.	Continue to monitor through weekly SITREP meetings	J Ryan	On-going	No delays in referrals	Green
	Enhanced training for clinical staff agreed with SOMPAR	J Ryan	Jan 12	Training records	Green
2. People with dementia who develop non-cognitive symptoms that cause distress, or who present with behaviours that challenge are considered for referral to the liaison service for further assessment.	Monitor through MDT meeting at ward level	Matrons/ Ward Sisters	On-going	Patient's notes	Green
	Review of effectiveness of referral process with SOMPAR at quarterly meetings. Routine weekly meetings as part of Discharge Management	J Ryan	On-going	MDT referral process	Green

Standard 3: Access to a specialist mental health liaison service LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. There is agreement about how and when a full multi-disciplinary liaison service is in place for the local general and community hospitals. This includes the provision of consultant psychiatrist time, and the required capacity to meet the needs of patients with dementia in general and community hospital settings.	Establish regular review meetings with SOMPAR to clarify the current service provision Participation in weekly SITREP review meetings in place	J Ryan/ S Saint	Jan, 2012	Agenda/Minutes	Blue
2. Commissioners assess need and determine activity levels for and outcomes delivered by the liaison service.	Report any shortfalls in service need to Somerset PCT	J Ryan	On-going	Evidence of service delays	Blue
3. Waiting times for referrals to the mental health liaison service are maintained within agreed timeframes.	Monitoring of delays in referrals are undertaken with SOMPAR	J Ryan/ S Saint	Jan, 2012	Review data quarterly and action accordingly	Blue
4. The role of the mental health liaison team includes the provision training for healthcare professionals in the hospital who provide care for people with dementia. This function is reflected in local training strategies.	Training programme for Dementia Champions and lead clinicians agreed with SOMPAR - Managing hydration – July - Challenging behaviour - September	J Ryan/ S Saint	Dec, 2011	●Attendance records. ●Enhanced confidence and competence within roles	Blue

Standard 4: Dementia-friendly environment, minimising moves LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. The hospital clinical champion determines the signage requirements of wards to assist people with dementia. Signage is installed.	●Incorporated into Dementia Working Group environment project on 6a/9a – see PID. ●All signage under review	J Ryan	Mar, 2012	Signage in place	Green
2. A good sensory environment is maintained with lighting free of shadows or glare; patients are able to see a clock from their bed area; availability of calendars.	PID development for 6a being developed in partnership with Facilities/Flying Colours/Art in Hospital PID shortly to be signed off - August	J Ryan/ M Carney/ James Kirton, Trust Fundraiser	Mar 2012	Implementation of project	Blue
3. Hospital policy endorses the principle that patients known to have dementia should not be moved between wards unless required for their care and treatment. Appropriate expertise should be brought to the patient rather than the patient being required to move.	Development and implementation of Wandering Patients Policy	M Groves/ J Hendrie	Dec 11	Policy implementation	Green
4. Patients should not be moved between wards between 8pm and 8am. Moves at mealtimes and medication times are also avoided.	●Roll out principles of Patient Centred Care (SIFF projects)	M Carney/ F Higginson	Mar, 2012	Audit	Green

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
Discussion regarding a required move takes place with the patient. Carers/families should be given adequate notice of a proposed move and asked if they wish to assist in the transfer.	●Guidelines for CSM's in support of Wandering Patients Policy	J Ryan/ M Groves J Hendrie	dec 11	Guidelines in place	Green
5. If a move is unavoidable the completed personal profile/wishes ('This is me' record) should be transferred to new ward along with all medical records. Key personnel identify themselves and implement full orientation policy.	Ensure all ward staff are engaged in the policy using high risk handovers	M Carney/ F Higginson	dec 11	Evidenced in patients notes	Green

Standard 4: Dementia-friendly environment, minimising moves LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. All key communal areas within hospital used by people with dementia are identified. The hospital clinical champion agrees appropriate adjustments to the environment (e.g. signage, easy to interpret menus and daily routines, coloured privacy doors).	Costed improvements to the League of Friends i.e.:- clocks, oasis points, Art in Hospital - Achieved clocks on order - Oasis point – 1 funded - Pictures funded for Ward 9a	J Ryan	Aug, 2011	Evidenced in practice	Amber

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
2. Daily therapeutic and recreational sessions or activities are available. Wards may include activities such as art therapy, music, gentle hand massage, activity boxes If discreet space is not available then activities are brought to the patient.	Review of Queensway Day Hospitals role in the dementia strategy	J Ryan/ M Whittuck	Jul, 2011	Outcome of review	Amber
	Occupation projects in line with SIFF to be rolled out	F Higginson/ M Carney	Mar, 2012	Evidence of activities in practice	Amber
3. Periodic review of impact on ward environment during periods of high / peak activity.	Reviewed daily at the Capacity Planning Meetings	Matrons	On-going		Green

Standard 5: Nutrition and hydration needs are well met LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. All patients will have a weight assessment on admission, at weekly intervals, and near to discharge (for inclusion in discharge summary). Minimum standard = 95% (exceptions: terminal illness, day cases, short elective, or not possible to weigh for clinical reasons).	Roll out of mandatory An Hour To Nourish to Flourish	K Head/ A Kyle	Jul, 2011	Attendance records	Green
	Mock CQC visits being arranged using agreed template DANI inspections August 2011	Associate Director of Nursing	Sep, 2011	Outcomes of visit and associated work plan	Green

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
2. All patients will be assessed using the 'MUST' tool or standard malnutrition universal screening tool. Minimum standard = 95%.	MUST Tool under review to ensure ease of use	A Kyle/ A Dowding/ J Ryan	Sep, 2011	Increased compliance of MUST audit in September, 2011	Green
3. Individual tastes, habits and eating preferences are identified and recorded in 'This is me' as part of the initial assessment in conjunction with carers. Minimum standard = 95%.	Roll out of "This Is Me" through Dementia Champions	Dementia Champions	ongoing	Evidenced in patients notes	Blue
	Carers/relatives leaflet in place Leaflets ready for implementation August	S Hawkins	Sep, 2011	Leaflet in place	Green
4. Protected mealtimes; volunteers, carers, friends actively encouraged to assist; patients sitting at a table more socially if they are able to, and wish to.	Enhanced signage for protected mealtimes in place in partnership with PPI	J Ryan/ S Hawkins	Sep, 2011	Signage in place	Green
5. Flexibility in provision and timing of food and in the presentation of food e.g. snacks and finger foods offered if necessary; recognising some patients may take a long time to eat a meal.	Mealtimes under review in line with patient centred care requirements Timing changed from September	J Ryan/ K Leins	Sep, 2011	Mealtime timetables	Blue

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
6. Coloured trays, utensils, crockery are used to support patients with dementia at mealtimes.	Use of red cups to aid hydration on order – already trialled successfully Order for remaining wards being placed	J Ryan	Jul, 2011	Evidenced in practice	Green

Standard 5: Nutrition and hydration needs are well met LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. There is access within 12 hours to specialist assessment for and advice on helping patients with dementia in their swallowing and eating, with information provided to carers / families.	Review current service provision with Speech and Language Team and make appropriate recommendations to commissioners as necessary	J Ryan	Aug, 2011	Outcomes of review	Amber

Standard 6: Promote the contribution of volunteers LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. There is a named senior clinical lead within the hospital with responsibility for defining the role and ensuring coordination and support of volunteers who promote wellbeing of people with dementia in the hospital.	Dementia Champions role being identified	K Head Yeovil Academy	Aug, 2011	Named individual	Green
	Befriender volunteer project under development with Alzheimer's Society	K Head	Aug, 2011	Volunteers in clinical areas (9a and 6a)	Green
2. A dementia care volunteer co-ordinator is identified.	To identify a befriender to undertake the role once up and running	K Head	Aug, 2011	Named lead	Green

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
3. Opportunities for enhancing the patient experience (mealtimes; social activities) are identified by ward champions with the appointed volunteer coordinator.	To develop with the Dementia Champions if role established	M Carney/ F Higginson	Nov, 2011	Timetable in place	Amber
4. Processes are agreed between volunteer coordinator and ward champions about the direction, support and feedback provided to volunteers and carers.	As above	M Carney/ F Higginson/ K Head	As above	Processes in place	Amber

Standard 6: Promote the contribution of volunteers LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. A regular review is undertaken about the opportunities for involving volunteers and plans for recruitment and retention to meet needs, which are agreed with the hospital clinical champion.	As above	As above	As above	As above	Amber
2. A range of training opportunities are offered at agreed periods for new and existing volunteers.	Dementia Befrienders attend an Hour to Remember	D Matthewson	On-going	Attendance records	Green

Standard 7: Quality of care at the end of life volunteers

LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. Patients with dementia identified as approaching their end of life [1] are flagged to General Practitioners for entry onto end of life care register and taking appropriate action.	End of Life register under implementation through Palliative Care Team	A Evans	On-going	Monitoring bt Palliative Care Team	Green
	Advanced Care Planning session planned for July, 2011 for lead clinicians, will incorporate a specific ACP for dementia Attendance from all staff groups improving. Next session planned in September	J Ryan/ J Howes/ T Coombes	Jul, 2011	Attendance sheets Achieved	Green
	Palliative Care Nurses attending Big Gov to raise profile Trust wide	A Evans	Jul, 2011	Attendance sheets Achieved	Green
	10 minute "mini" teaching sessions on wards	Palliative Care Team	Mar, 2012	Attendance sheets	Green

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
2. All patients with dementia who remain in hospital to die are cared for using the Liverpool Care Pathway[2] or agreed integrated care pathway for care of dying.	Involvement in LCP audit	Palliative Care	Sep, 2011	Audit outcomes	Green

Standard 7: Quality of care at the end of life volunteers LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. All clinical and support staff working with people with dementia requiring end of life care have received appropriate training. Minimum standard = 100%.	Attendance at In House – Dying Matters sessions for clinical staff Achieved	Palliative Care	Jun, 2011	Attendance sheets	Green
	Attendance at Advanced Care Planning training Achieved	J Ryan/ J Howes/ T Coombes	Jul, 2011	Attendance sheets	Blue

Standard 8: Appropriate training and workforce development LEVEL 1

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. All new staff receive mandatory induction in caring for people with dementia based on South West standards and required competences.	Training programme – An Hour To Remember delivered November – March, 2010/11	J Ryan	On-going for new staff	Attendance sheets	**Green**
2. There is a dementia training framework in place and a strategy for implementation agreed. The framework identifies competences required for working with and caring for people with dementia. The framework utilises the mental health liaison service within the hospital. Training includes, as a minimum: • dementia awareness; • communication skills, and working with older people with sensory impairment; • addressing behaviours that challenge; • assessing capacity, and the Mental Capacity Act; and • the protection of vulnerable adults.	●Dementia Champions training sessions with follow up workshops and support meetings. ●QCF Workshop programme at Level 2. ●Training Strategy for vulnerable adults. ●Accreditation framework for dementia (QCF) agreed.	B Garnett D Matthewson	Mar, 2012	Training strategy	**Green** **Green** **Green** **Green**

Standard 8: Appropriate training and workforce development LEVEL 2

Criteria	Actions	Lead	Deadline	Improvement indicators	Status Tracking
1. The training and knowledge framework is implemented.	Training and knowledge framework will be replaced at Yeovil by QCF who run accredited dementia training.	D Matthewson	Sep, 2011	Attendance records	Blue

Risk assessment log

Risks	Priority	Mitigation	Lead	Review date	Progress 2012
1. Unable to establish a dementia care volunteer co-ordinator	High	Determine with Trust Board Dementia lead how to achieve this Befriender's Day now organised for 18 November	J Ryan	December, 2011	Achieved
2. Occupation	High	Music at ward level. J Ryan meeting with Rosanna (Music Project) on 22 November 2011. Memory boxes - source resources and pilot	J Ryan R Tonkin D Mathewson	March 2012 March 2012	Achieved Achieved

FLYING COLOURS
for Yeovil Women's Hospital

Yeovil District Hospital NHS
NHS Foundation Trust

Our Ref: LW/VAW/26.1

Yeovil District Hospital
Higher Kingston
Yeovil
Somerset
BA21 4AT

26 April 2012

Switchboard: 01935 475122
Direct line: 01935 384414
Email: gini.wells@ydh.nhs.uk
www.yeovilhospital.nhs.uk

Ian Tipney
Chief Executive
NHS Somerset
Wynford House
Lufton Way
Yeovil
BA22 8HR

Dear Ian

OVERNIGHT DISCHARGES FROM NHS TRUSTS

I am writing in response to your letter dated 19 April 2012 requesting assurance of appropriate discharges of patients overnight from NHS Trusts.

Yeovil District Hospital is committed to providing high quality safe care for all of our patients and the Board of Directors review patient quality and safety issues on a regular basis. The risk resulting from inappropriate overnight discharges was discussed at our Board of Directors meeting on the 18 April 2012. Assurance was given from both our Medical Director and Director of Nursing and Clinical Governance that inappropriate discharges are not made during the night and where at all possible discharges are not made from inpatient areas during the night. This was backed up further with confirmation from the Clinical Site Managers that they do not experience discharges from inpatient wards after 11pm, and this is all in line with our iCARE culture at Yeovil District Hospital.

I have reviewed the complaints over the last 12 months and there have been two complaints regarding overnight discharges both of which related to discharges from the Emergency Department and not from inpatient areas. Following these complaints further action has been taken to ensure vulnerable patients are supported to go home from the Emergency Department.

After reviewing the discharge times on our bed administration system (that forms part of the patient administration system, PAS), it is apparent that live discharges are not recorded throughout the night and therefore I cannot provide data as a source of assurance on overnight discharges. Live discharges are recorded throughout the day but due to lower clinical administration support throughout the night live discharges have not been recorded. This is now being addressed and actions are being put in place to ensure that all discharges are recorded as they happen so that we

can gain further assurance through the use of this data. All overnight discharges will then be reviewed to ensure they were in the best interests of the patient.

I trust this provides you with the information you require on overnight discharges and assurance that we are not inappropriately discharging patients overnight at Yeovil District Hospital. If you require anything further, please do not hesitate to contact me.

Yours sincerely

LIBBY WALTERS
ACTING CHIEF EXECUTIVE

cc Sue Jones, Director of Nursing and Clinical Governance
Dr Jon Howes, Medical Director
Jonathan Higman, Director of Operations
Lucy Watson, Director of Nursing and Patient Safety

Report to: **Board of Directors**
Report from: **Director of Estates and Facilities**
Subject: **Estates and Facilities Report**
Date: **16 May 2012**

APPENDIX 8
BOARD OF DIRECTORS
16 MAY 2012

1. Introduction

The purpose of this report is to provide an update about current Estates and Facilities activities, key messages and performance.

2. Yeovil Health Campus

Separate progress report presented for the Yeovil Health Campus Project.

3. Preston Road Clinic

REDACTED DUE TO COMMERCIAL SENSITIVITY

4. Energy Centre and Infrastructure

Interviews were held on the 30 March with high scores achieved and four contractors shortlisted to proceed to technical presentations stage on the 12 April.

REDACTED DUE TO COMMERCIAL SENSITIVITY

The revised objectives for the project are set out as:

- Achieving compliance with the initial round of carbon reductions for the site for 2015
- Achieving carbon, energy and financial savings
- Making provision for future site development
- Reducing site backlog

The next steps in the procurement process are the stage two technical presentations.

The outline programme for this project is:

Yeovil District Hospital	Status	Date 2012
Release ITMC	Complete	24 Feb 2012
Open day	Complete	16 Mar 2012
Interviews	Complete	30 Mar 2012
Technical meeting 1	Complete	12 Apr 2012
Technical meeting 2		1 May 2012
Outline Business Case		***May 2012***
Release ITT		4 May 2012
Mid term review		31 May 2012
Bids received		25 Jun 2012

Presentations		28 Jun 2012
Evaluation		11 Jul 2012
Preferred bidder announcement		27 Jul 2012
Full Business Case		***Jul 2012***
Contract meeting 1		15 Aug 2012
Contract meeting 2		5 Sep 2012

5. Capital Projects

The progress of capital projects with expected dates for key milestones is as follows:

Women's Hospital Refurbishment:

Main Entrance

All work is now complete with final account 99% agreed. Liquidated damages of £5k applied due to late completion of work.

Birthing Pool

Works 98% completed; room brought into use for Easter Holiday period to relieve potential space pressures. Commissioning of birthing Pool planned for Apr 2012. Snagging list currently being resolved.

Clinic Rooms (Ground Floor)

Tenders received on the 12 April 2012 with costs within budget although tender analysis still to be completed. Work is expected to commence in May 2012 subject to funding. A bid for Trust Funds was submitted on the 7 Mar 2012.

Special Care Baby Unit (SCBU)

Further feasibility work to be carried out enabling the design and tender stage for the project. A delivery plan has been developed to show start on site in early 2013 and completion in Aug 2013 subject to feasibility, funding and planning.

Key Dates / Milestones:	Ground Floor Clinic Rooms:	Completion - November 2012
	SCBU:	Completion - 2013

Nursery: Two strong bids have been received although the tender analysis is on-going due to the business models proposed which have financial implications for both SSDC and YDH. Site visits have been made for the staff from both organisations and presentations to nursery staff, parent's representatives and members / governor is arranged for the 25 Apr 2012.

Key Dates / Milestones:	Short list / tender clarification – April 2012 Preferred supplier – May 2012 New operator / contract start – July 2012

New Residences: Good progress continues to be made with the construction work on programme. A follow up site visit to the new residences at St Georges Avenue was made on the 19 Apr 2012 with Yarlington Housing Group. The new accommodation is being actively advertised and booking enquiries are now being made for the August intake of Junior Doctors and for the transfer of existing tenants.

Key Dates / Milestones:	Trust's contract with YHG:	Construction completion – July 2012 Occupation – August 2012

Electrical Infrastructure: Upgrade work is continuing for the hospital's electrical infrastructure including the replacement of main electrical switchgear panels and mains cabling. The work has been phased over the next three years due to the significant costs involved, complexity and in order to minimise disruption to hospital activities.

A partial upgrade of the main cabling network will commence in May 2012 with completion in 2013. The Women's hospital panel will be completed in Jun 2012 and replacement of switch room 'B' for the main hospital has been scheduled for commencement in Apr 2013.

This is essential backlog works to replace and upgrade obsolete and life expired infrastructure with a total cost in the region of £350K which is necessary to ensure safe and secure electrical supplies for the hospital.

Key Dates / Milestones:	Women's Hospital Panel	Completion – Jun 2012
	Switch Room "B" Panel	Completion – Aug 2013
	LV Network Cabling (phase a)	Completion - 2014
	LV Network Cabling (phase b)	Completion - 2015

Hot Water System (Level 2 Plant Room): The installation of the plate exchanger units is complete with both new units commissioned and operational. Additional works planned to resolve historic circulation problems which are necessary for legionella compliance. The removal of the final hot water calorifer and associated asbestos materials will commence at the end of April for 4 weeks.

Key Dates / Milestones:	Completion (phase two) – May 2012

CT Scanner Replacement: New CT Scanner is delivered and installed with commissioning planned for the 17 Apr 2012. Training has been re-scheduled and patients list adjusted to start later in Apr 2012.

The temporary scanner will be retained for a further week. All redundant services have been removed and a number of engineering service defects identified and resolved as part of the project.

Key Dates / Milestones:	Completion - May 2012

Fire Alarm System Upgrade: Design work completed and being reviewed prior to sign off. Phase two of Women's Hospital is being undertaken direct as part of those works. Asbestos removal and making safe works has been put in place and budgets agreed over the next 3 years.

Key Dates / Milestones:	Completion - 2014

SSD Plant Deck Defect: Remedial work progressing well ahead of the programme. The first plant changeover on the new deck was completed over Easter with the third crane lift of the ventilation plant carried out on the 14 Apr. The second changeover will not require a close-down of SSD. The internal works were completed on the 13 Apr and a new programme of works to include deconstruction of the old plant deck will be provided in April.

Key Dates / Milestones:	Completion - August 2012

6. Security Management

Recent changes to the standard commissioning contracts by the Department of Health have resulted in revisions to the security management requirements which now affect all providers. The key revisions require all providers to put in place appropriate security management arrangements, to carry out a crime risk assessment and mitigate any identified risks in line with NHS Protect guidance. Increased responsibilities are also included for the Local Security Management Specialist (LSMS) to review security management provisions and to implement any modifications recommended.

The contract also enables NHS Protect to review the provider's security management provisions and to implement any modifications recommended or to ensure that NHS Protect is given access to property, premises, information and staff for the purpose of detecting and investigating security incidents and breaches.

The Trust has agreed an SLA with Taunton and Somerset NHS FT to share the Local Security Management Service (LSMS) which commenced in April 2012 although the training will now be completed in May 2012. All security incidents or security breaches will be reported to the LSMS, NHS Protect and to the Trusts Security Committee.

7. External Review of Estates and Facilities

The diagnostic review of the four work streams has been completed in conjunction with Birch Foundation for cleaning, catering, logistics and maintenance services with recognition of the previous and on-going service improvements which have already achieved significant savings but with scope for further improvement. A presentation of the findings is planned for the 23 Apr 2012 to review the business case for implementing the work streams and training will also be provided to build capacity and complete the Yeovil Lean Training Certificate.

8. Performance Management Dashboard

The performance dashboard for the month of March 2012 is attached. No changes have been made to the dashboard this month.

9. Recommendation

The Hospital Management Team and Board of Directors are asked to DISCUSS the content of the EFM report.

Yeovil District Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors	APPENDIX BOARD OF DIRECTORS 16 May 2012
Report from:	Director of Planning & Performance	
Subject:	Performance Report	
Date:	16 May 2012	

1 Introduction

1.1 This report sets out an overview the performance of the Trust during the month of March 2012. It provides a summary of performance in key areas, and highlights the main risks and issues.

1.2 The report is structured as follows:

- Performance overview and key points from the corporate dashboard
- Separate sections setting out more detail on performance in the four key areas of:
  - quality and patient experience;
  - service delivery;
  - human resources
  - finance.

2 Performance Overview

2.1 This section highlights the key points within the performance report for the Board's attention:

- The rolling 12-month Hospital Standardised Mortality Ratio (HSMR) has now fallen to 100.4, down from 117.4 when rebased in June.
- There were two C difficile cases in March which brought the year-end position to 23, against a year end maximum number of 29.
- Performance against the 4 hour A&E standard was 97.8% in March, bringing the quarter four position to 95.08%.
- Despite fears that the work to reduce the waiting list to achieve a maximum 18 week admitted wait in all specialities would mean that the Monitor standard was not achieved in quarter four, the 95th percentile wait was 22.5 weeks, which was within the target of 23 weeks.
- The Trust is an outlier for slot availability through the Choose and Book system for outpatient appointments. The most recent performance data indicates that for 22% of the patients who attempted to book an appointment at YDH there were no available slots to book into.
- Financial performance improved again and stood at £718,000 ahead of plan at the end of March, with a surplus of £993,000.
- The Trust was Green against the governance element of the Monitor Compliance Framework.

3 April Position

3.1 This report focuses on performance in March 2012, and is based on the dashboard for the year 2011/12. Some performance data for April was available at the time of writing, and the key points were:

- 95.0% of patients were seen within 4 hours in the emergency department
- Unvalidated data suggests that the 18 weeks referral to treatment target was achieved for both admitted and non-admitted patients, although not in all specialities.
- There were no C difficile or MRSA cases in April.

4 Corporate Dashboard (Annex 1)

4.1 The main tool by which the Board receives assurance on the Trust's performance is the Trust's dashboard. This contains the key targets which the Trust is required to meet by the Department of Health or its commissioners. This report is the last based on the dashboard for the year 2011/12. A revised dashboard will be in place for 2012/13.

4.2 This section highlights key risks or issues within the corporate dashboard:

Personal, high quality and safe care

- Objective: Reduce HSMR year on year by 2.5%: Dr Foster carried out the annual rebasing of their HSMR figures in September with the result that the rolling 12 month HSMR increased to 117.5. This has now fallen back to 100.4 which is closely in line with the Trust's expected rate of 100. Reviews of notes in key areas continually demonstrate that the Trust provides a high quality of care. Changes have been made to the recording of patient allocation to consultants on the PAS system which has reduced the number of episodes per spell to levels in line with other trusts, and should have a positive impact on our HSMR. The new coding software went live in January, which is also expected to improve our position, along with the continuing work programme of the Dr Foster Steering Group.
- Objective: Maintain low infection rates: There were two C. difficile cases in March so the end of year total was 23, which was below the maximum target number of 29.
- *Objective: High quality stroke care:* Performance against both stroke indicators has been inconsistent during the year; however, both the stroke ward and TIA targets were achieved in February and March. The NHS Institute has been working with the team to redesign the pathway within the Trust in order to enable consistent achievement of both targets.
- Objective: High quality patient pathway: The readmission indicator has been red since April 2011. This was discussed at the December Hospital Management Team meeting and an action plan is being implemented to address the issues around recording, contract negotiations, and to ensure there are no clinical issues of concern, although it needs to be closely monitored to ensure performance improves.

Strong, sustainable services, meeting local needs

- Objective: Waiting times: All three of the new waiting time indicators were achieved, despite concerns that the overall admitted target would be missed due to reducing the number of longer waiters. From April, these indicators will need to be achieved at speciality level and work is in progress to achieve this over a four month period.
- Objective: A&E waits: Performance in February against the 4 hour standard was 92.9%. Performance improved significantly in March, and the position for the quarter was 95.08% which meant that the quarterly Monitor governance rating requirement was achieved.
- Objective: Cancer waits: All cancer targets were achieved in March.

Our staff are our greatest strength

- Performance in March was consistent with previous months. Appraisal and mandatory training rates are static at around 73% and 67% respectively. Further work is being undertaken to improve them.

A valued partner in the local health service

- GP referrals were above plan in four out of the last five months, but below plan in March. The full year performance in respect of GP referrals was 3.2% below plan.

To manage our money wisely

- Objective: Achieve a financial risk rating of 3: The Trust position improved from £113,000 above plan to £718,000 above plan for income and expenditure at the end of March. 100% of cost improvement plans were in place at the end of March.

Infrastructure to support delivery

- Progress is on track against the Estates Strategy, and the IT Strategy has been relaunched. Procurement of major new hospital systems has now commenced.

5 Monitor Compliance Framework

5.1 The Trust achieved a Green rating for governance in quarter three. 18 weeks admitted performance, and 4 hour performance were risks for quarter four. After much hard work by many staff, both were achieved at the end of March, which has resulted in a governance rating of Green for quarter four.

6 Clinical Quality and Patient Safety (Annex 2)

Key Points

- The year-end C difficile target was achieved, with 23 cases against a maximum target of 29
- There were two cases of MRSA during the year, exceeding the Trust's contractual target of 1, but well within the governance framework requirements set by Monitor
- The hospital's Standardised Mortality Ratio (HSMR) continues to fall and has been below 100 for 6 months.
- Performance against the internal targets to reduce falls and pressure ulcers are behind plan.

Clinical Quality

6.1 There were two C. difficile cases in March which brought the year-end total to 23, well below the maximum target number of 29.

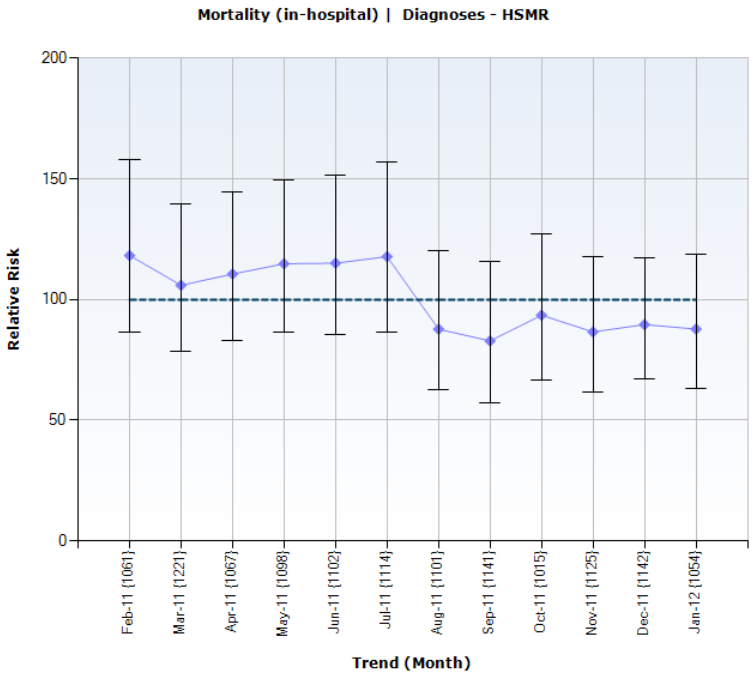
6.2 There were no MRSA cases in March, which left the total for the year unaltered at two cases, one of which was a contaminated sample. The Trust's contractual maximum of one case was exceeded, but the level was well below the de-minimis level of 6 set by Monitor in its Compliance Framework.

6.3 The infection prevention and control key performance indicators, which provide more detail, are attached at annex 2a.

6.4 The Hospital Standardised Mortality ratio (HSMR) for the most recent rolling 12 months was 100.4, and the in-month figure for January was 87.8. The HSMR has been below 100 for six successive months.

6.5 The new Department of Health Summary Hospital-level Mortality Indicator (SHMI) is 108.6 (July 2010- June 2011), which is within expected limits for a trust this size.

6.6 The chart below shows the trend in the Trust's HSMR over the last year.



6.7 The target to ensure that 90% of patients are assessed for VTE risk and are recorded as such on PAS was achieved for the first time in March.

6.8 Performance against the key internal patient safety targets for the year to the end of February is summarised below. It should be noted that due to the lag in reporting of incidents, the data for incident reports is one month in arrears.

	February data	**YTD data**	**YTD target**	**Variance (%)**	**Full year target**
VTE - % patients with completed risk assessment	91.1%	76.5%	90% (March)	+1.1%	90%
Patient safety incidents reported	212	2530	2329	+ 201 (+8%)	2541
Patient Falls	73	778	759	+ 19(+2%)	828
Rate per 1,000 bed days	8.29	8.43	6	Above target	6
Percentage falling more than once	24%	25%	25%	On target	25%
Hospital acquired pressure ulcers (grade 2 and above)	13	169	8 (in-month target for February)	+5 (+19%)	26 in quarter 4
Rate per 1,000 bed days	1.48	1.82	1.5	February Year to date	1.5
Root Cause Analysis investigations (March)	4	78	54	On target	54

6.9 Four new root cause analysis reviews were commissioned in March; one related to a patient undergoing an MRI scan despite the presence of a pace-maker, two patients fell and sustained fractures (one wrist and one cervical spine) and one case reported the misinterpretation of radiology results.

6.10 A total of 14 remain open and under investigation, and the themes identified in these open reviews are as follows:

- 2 falls resulting in a fracture
- 7 concerns about clinical treatment
- 1 hospital acquired pressure sores Grade 3 and above
- 1 retained dental screw (Never Event)
- 1 unexplained death
- 2 misinterpretation of investigation results

6.11 A number of actions have been completed as a result of completed investigations, including:

- Further education in the monitoring and documentation of pressure sores
- Development of a policy for patient transfer
- Use of South West Peninsular Critical Care Transfer forms

- Introduction of new nursing documentation
- Continued development of care bundles
- Ongoing review of all deceased patients' records
- Audit of practices in place in delivery rooms in respect of swab counts

6.12 The Trust uses an early warning tool called the Swiss Cheese to detect an early signs of potential patient safety in issues within clinical areas. This tool has been adopted across the South West region and is being used in all acute trusts.

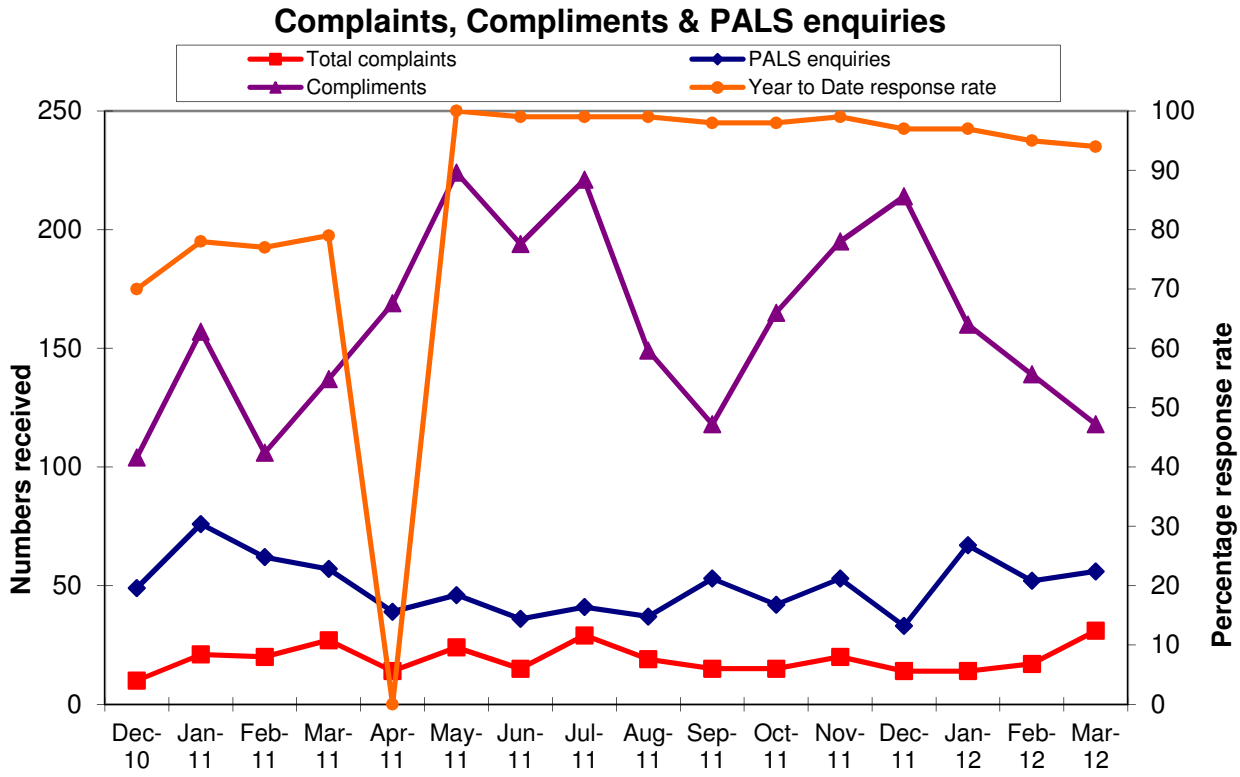
6.13 The indicators describe the most important conditions necessary for a well-functioning team. The tool prompts staff to make a judgement against the key indicators and then it automatically weights and scores them according to their importance. An overall score of more than 12 indicates that remedial action needs to be taken to prevent a later impact on the quality of care provided within that area. Each clinical area's assessment is reviewed by peers from another area to ensure consistency and a robust approach.

6.14 In February two areas were rated amber (scores between 9 and 11): the emergency admissions unit and the Kingston Wing. Two areas were rated red: the emergency department and ICU with scores of 12. 7 areas did not report, which was unusually high. The remaining 14 were green.

6.15 The Trust was subject to an unannounced inspection by the Care Quality Commission on 22 March. This was part of a national programme of reviews of all organisations licenced to perform termination of pregnancies and focused on compliance with the legislation. Initial feedback was positive, with the inspector confirming that our pathway and practice comply with the legislation; however, some of our record keeping was incomplete and could be improved. The inspector commented on the good care our patients receive.

Patient Experience

6.16 Patient complaints and concerns raised via the Patient Advice and Liaison Service continue to provide the Trust with valuable insight into the patient experience. This should be considered in conjunction with the data available from patient surveys, including national, Your Care and EXIT surveys. The following chart shows the trend data in respect of complaints, PALs enquiries and compliments.



6.17 The overview information in respect of in-house patient satisfaction surveys is outlined in the table below :

	March data	**YTD data**	**YTD target**	**Variance (%)**	**Full year target**
Your Care surveys completed	151	1799	1958	-159(8%)	2136
Overall care rated excellent	56%	65%	80%	Below target	80%
Staff attitude rated as excellent	62%	69%	80%	Below target	80%
Bathroom cleanliness rated as excellent	85%	82%	80%	Achieved target	80%
EXIT surveys completed	71	1057	864	+ 193 (22%)	942

7 Service Delivery

Key Points

- As a result of strong performance in March, the Trust delivered all of the Monitor performance standards across Quarter 4 and maintained a green governance rating.
- There is a risk of not achieving the new requirement to deliver the referral to treatment (RTT) waiting time targets at speciality level from April in a small number of specialities.

Referral to Treatment (RTT) Waiting Time Targets

7.1 The Monitor compliance framework includes the following two RTT targets:

- 95th percentile wait for admitted pathways (target 23 weeks)
- 95th percentile wait for non-admitted pathways (target 18.3 weeks)

7.2 In addition, the Department of Health continues to monitor the previous RTT targets (90% within 18 weeks for admitted pathways and 95% within 18 weeks for non-admitted pathways). A 95th percentile target of 28 weeks has also been added for incomplete (on-going) pathways.

7.3 Despite the risks highlighted previously, associated with the delivery of the RTT plan at specialty level, the Trust continued to achieve all five standards during March. Performance can be summarised as follows:

	Target	Standard	Achievement
MONITOR/DoH	95th percentile wait for admitted pathways	**23 weeks**	**22.5 weeks**
MONITOR/DoH	95th percentile wait for non-admitted pathways	**18.3 weeks**	**15.5 weeks**
DoH	Admitted – percentage of patients within 18 weeks	**90%**	**92.2%**
DoH	Non-admitted – percentage of patients within 18 weeks	**95%**	**96.7%**
DoH	95th percentile wait for on-going pathways	**28 weeks**	**18.5 weeks**

7.4 From 1 April there is a new national target that the RTT standards should be achieved across all specialities. A plan to achieve this target for admitted patients has been agreed as part of the contract with NHS Somerset, whereby fines will be imposed for underachievement at specialty level from April 2012, with the exception of orthopaedics and oral surgery, where delivery from July 2012 has been agreed. This plan is currently on track, although there remains a risk in relation to oral surgery due to a shortage of medical staff in this speciality.

7.5 Due to the complexity of some pathways and the effect which the small numbers of patients in some specialties can have on percentages, the major risk to the delivery of the new specialty-based targets is non-admitted pathways, and in particular oral surgery and plastic surgery.

7.6 The Trust continues to make good progress against the two new NHS Operating Framework standards for waiting times, which become live from 1 April 2012. These are:

- 92% of patients on incomplete pathways waiting less than 18 weeks
- No more than 1% of patients waiting longer than six weeks for a diagnostic test

7.7 Both of these standards were achieved during March.

7.8 Progress against the standards which will be in place from 1 April 2012 can be summarised as follows:

		Target	Nov - 11	Dec - 11	Jan - 12	Feb-12	Mar-12
MONITOR/DoH	Admitted RTT Performance	90%	91.9%	93.2%	90.8%	90.8%	92.2%
DoH	Admitted specialties not achieving 18 weeks	0	2	3	2	4	2
MONITOR/DoH	Non-admitted RTT Performance	95%	95.5%	95.2%	95.1%	95.3%	96.7%
DoH	Non-admitted specialties not achieving 18 weeks	0	4	6	7	7	5
MONITOR/DoH	Patients on incomplete pathway waiting 18 weeks or less	92%	80.6%	82.2%	93.3%	95.0%	94.6%
DoH	Proportion of patients waiting longer than six weeks for a diagnostic test	1%	0.3%	1.0%	1.3%	1.5%	0.1%

Cancer Waiting Times

7.9 Data for the cancer targets are sourced from the Somerset Cancer Register and continue to be fully validated one month in arrears. March data is, therefore, draft at this time and will be fully confirmed in mid-May. Performance is summarised in the first table on the next page.

7.10 Areas of note are as follows:

- The Trust achieved all of the Cancer standards during March 2012 and across Quarter 4, representing continued strong performance.
- The key risk within cancer services remains access to Oncology from the Beacon Centre. This continues to be managed at an operational level. The Trust is reviewing its service model for oncology provision and is in discussion with Taunton and Somerset NHS Foundation Trust regarding the direct employment of an oncologist to YDH.

Summary of Cancer Waiting Times Performance 2011/12

	Verified Open Exeter															DRAFT									
	Q1 Total			Q2 Total			Q3 Total			Jan-12			Feb-12			Mar-12			Q4 To Date			2011/12 Year to Date Total			Target
	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	
2WW for all urgent cancers	90	1157	92.2%	64	1111	94.2%	80	1186	93.3%	24	363	93.4%	17	435	96.1%	30	466	93.6%	71	1264	94.4%	305	4718	93.5%	93%
2WW for Asymptomatic Breast Patients	8	127	93.7%	7	138	94.9%	4	133	97.0%	2	47	95.7%	1	53	98.1%	1	46	97.8%	4	146	97.3%	23	544	95.8%	93%
31 DAY TARGET 1st treatment	2	165	98.8%	2	158	98.7%	1	150	99.3%	1	73	98.6%	2	57	96.5%	1	66	98.5%	4	196	98.0%	9	669	98.7%	96%
31 DAY TARGET for subsequent treatments - DRUGS	0	30	100.0%	0	34	100.0%	0	44	100.0%	0	14	100.0%	0	12	100.0%	0	12	100.0%	0	38	100.0%	0	146	100.0%	98%
31 DAY TARGET for subsequent treatments - SURGERY	1	43	97.7%	2	53	96.2%	0	34	100.0%	0	17	100.0%	0	6	100.0%	0	16	100.0%	0	39	100.0%	3	169	98.2%	94%
62DAY TARGET for 2WW referrals	13	116	88.8%	8.5	98	91.3%	8	97.5	91.8%	2	48.5	95.9%	4	39	89.7%	4	40.5	90.1%	10	128	92.2%	39.5	439.5	91.0%	85%
62DAY TARGET for national screening	0.5	3	83.3%	0	2	100.0%	1	3	66.7%	0	0.5	100.0%	0	2.5	100.0%	0.5	5.5	90.9%	0.5	8.5	94.1%	2	16.5	87.9%	90%
62DAY TARGET for consultant upgrades	1.5	27	94.4%	0	31.5	100.0%	0.5	20	97.5%	0	15.5	100.0%	0	6	100.0%	0	14	100.0%	0	35.5	100.0%	2	114	98.2%	90%

Summary of Performance Against Emergency Department Quality Standards 2011/12

	Target	Standard	Q1 Total	Q2 Total	Q3 Total	Jan-12	Feb-12	Mar-12	Q4 Total	Total
MONITOR	Percentage of patients spending four hours or less in the Emergency Department	95%	95.02%	96.96%	96.65%	94.26 %	92.85 %	97.80 %	95.07%	95.92%
DoH	95th Percentile wait in the Emergency Department	≤ 4 hours	4:00 hrs	3:59 hrs	3:59 hrs	4:28 hrs	4:53 hrs	3:58 hrs	4:00 hrs	4:00 hrs
DoH	95th Percentile wait from arrival to initial assessment for ambulance patients	≤ 15 mins	37 mins	31 mins	25 mins	25 mins	30 mins	24 mins	27 mins	30 mins
DoH	Median waiting time from arrival to treatment	≤ 60 mins	1:13 hrs	1:06 hrs	50 mins	56 mins	1:08 hrs	58 mins	1:01 hrs	1:02 hrs
DoH	Un-panned re-attendance rate (within 7 days)	≤ 5%	3.5%	3.3%	3.5%	2.9%	3.7%	3.8%	3.5%	3.4%
DoH	Percentage of patients who left the department without being seen.	≤ 5%	2.4%	2.7%	1.6%	2.0%	1.8%	2.1%	2.0%	2.2%

Emergency Pathways

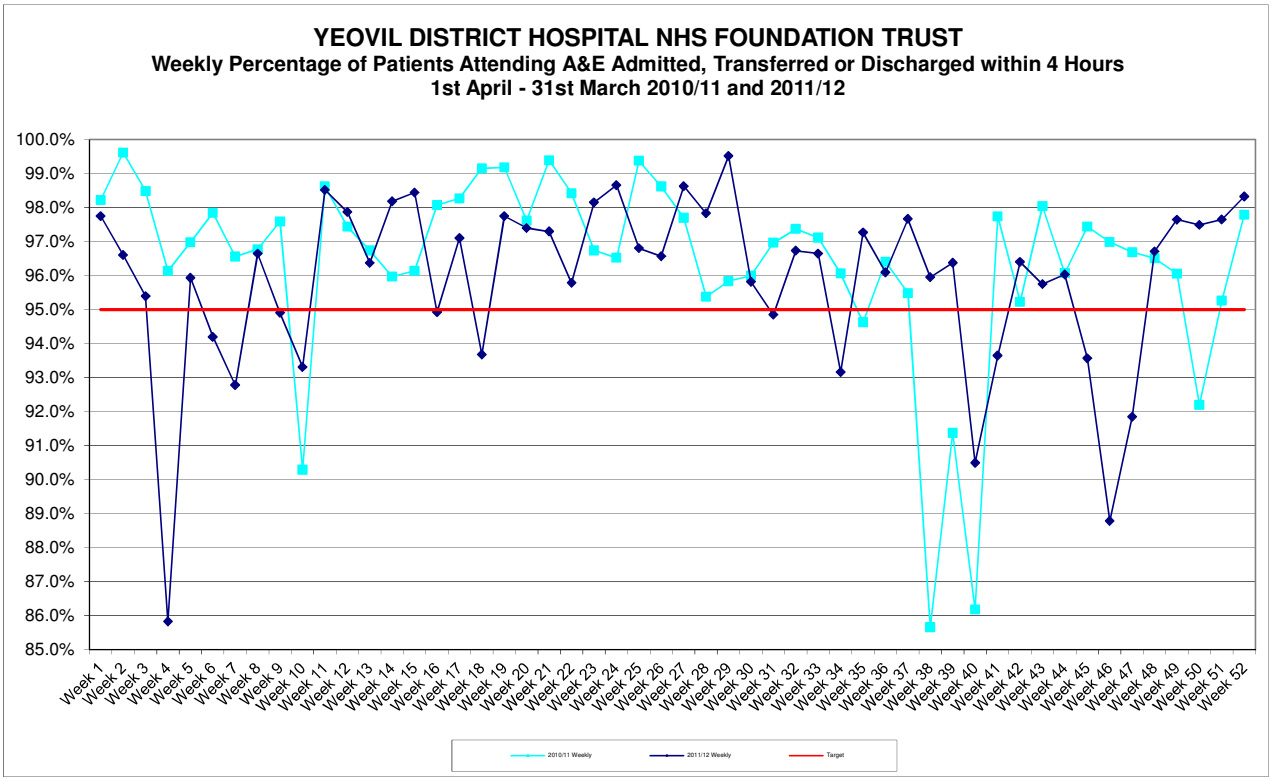
7.11 Performance against the six Emergency Department standards for the year to date is summarised in the second table on the previous page.

7.12 The Trust delivered strong performance against the 4-hour standard during March, with performance of 97.85%. This resulted in performance of 95.07% across Quarter 4 and 95.9% across the year as a whole.

7.13 Significant operational attention was paid to recovering the quarterly position following under-achievements in both January and February. This involved significant personal contributions from a number of individuals, which should be noted.

7.14 However, the aim moving forward is to focus effort on reducing the current variability through the delivery of the Emergency Care Pathway Transformational project.

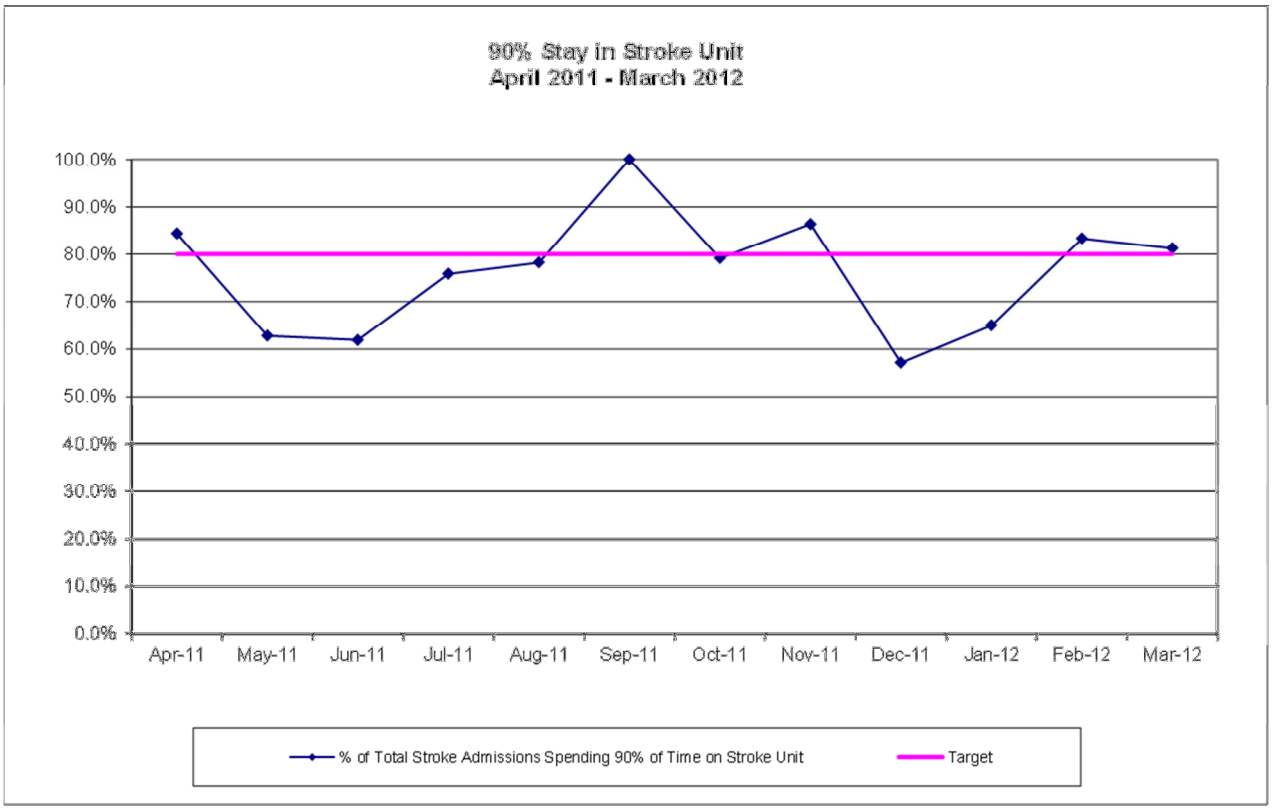
7.15 Weekly performance against the 4-hour standard across the year can be summarised as:



Stroke Care

Patients Spending 90% of their time on the Stroke Unit – (Target 80%)

7.16 A key indicator of the quality of stroke care delivered by the Trust is the percentage of patients spending 90% or more of their stay on the Stroke Unit.



7.17 The standard continued to be achieved during March with 81.3% of stroke patients admitted spending 90% or more of their time on the Stroke Unit.

7.18 This standard is now being delivered more consistently than in the past. However, there remains a degree of variation which needs to be reduced. In order to deliver a more sustained level of performance, the Trust is working with the NHS Institute for Innovation and Improvement to undertake a Stroke Pathway review. This work commenced on 4 April 2012 and is focussing on the internal pathway to streamline admission from the Emergency Department directly to the Acute Stoke Unit. An action plan has been developed to support this.

7.19 In addition, the Trust is working with NHS Somerset and Somerset Partnership NHS Foundation Trust to improve the process for transferring patients for on-going rehabilitation to the South Petherton Stroke Unit and in a review of the Early Supported discharge scheme.

TIA Clinic – High risk Transient Ischaemic Attacks (TIAs) receive treatment with 24 hours of referral (Target 60%)

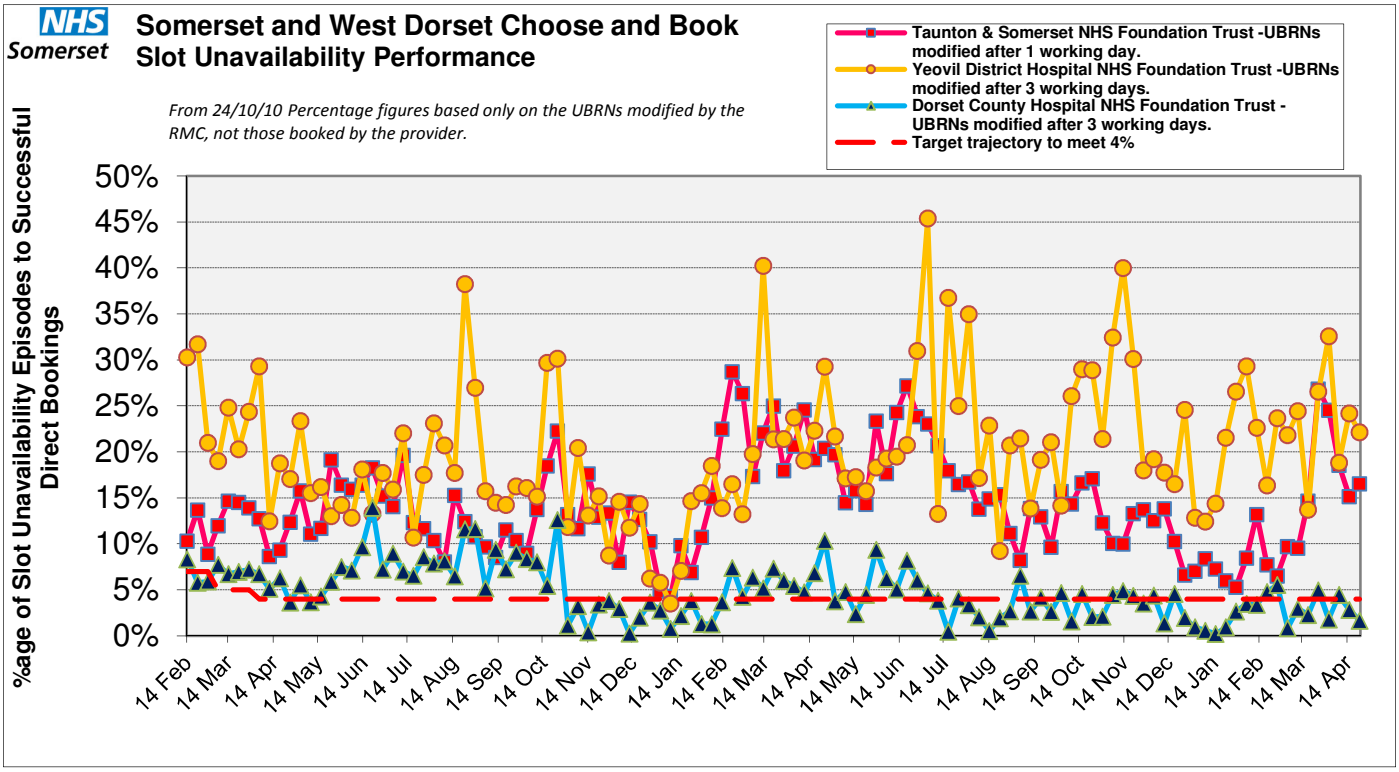
7.20 This standard was achieved during March, with 88.9% of patients being seen and treated within 24 hours.

Seen and treated within 24hrs?	**Q1**	**Q2**	**Q3**	**Jan-12**	**Feb-12**	**Mar-12**	**Q4**	**Total**
Yes	13	16	18	4	5	8	17	64
No	3	7	5	4	2	1	7	22
TOTAL HIGH RISK TIAs	**16**	**23**	**23**	**8**	**7**	**9**	**24**	**86**
% of High Risk TIAs Seen and Treated within 24hrs	**81.3%**	**69.6%**	**78.3%**	**50.0%**	**71.4%**	**88.9%**	**70.8%**	**74.4%**

Slot Availability

7.21 The Trust is an outlier for slot availability through the Choose and Book system for outpatient appointments. The most recent performance data indicates that for 22% of the patients who attempted to book an appointment at YDH there were no available slots to book into.

7.22 The graph below shows YDH's performance against that of other local trusts:



7.23 An action plan to address this issue has been agreed with Somerset PCT which focuses on ensuring that there is sufficient capacity available to meet patient demand, and also that as many services as possible are made available for direct booking through the Choose and Book system.

8 Human Resources (Annex 3)

Key points

- Seven out of eight HR indicators were positive this month (see appendix 3a).
- The pay underspend remained at £498k.

Staff in post against vacancies

8.1 The vacancy position increased in March from 59 to 64 and is green. Vacancies are fairly evenly spread across Divisions.

8.2 The position on medical vacancies has improved following overseas recruitment of additional middle grade doctors which is encouraging. The Clinical Director for Emergency Medicine has also developed a comprehensive workforce plan to reduce middle grade vacancies in that department which are to be implemented shortly.

Pay Budget Spend

8.3 The pay budget underspend increased again to £388k for the year. The reduction in agency spend compared to the same time the previous year was maintained. The spend over the whole year was £2million, compared to £2.8 million this time last year. Medical locum costs in particular were less than half the cost of the same period in 2010/11 - down from £1.5 million to £740k which is very positive.

8.4 The Trust is currently awaiting a national decision on whether to continue to run clinical excellence awards for medical staff before commencing this process locally.

8.5 Clinical on call arrangements for staff within the Agenda for Change pay bands are being reviewed with a view to standardisation in order to facilitate round the clock services in line with the aims of the clinical services strategy.

Sickness Absence Management

8.6 Sickness absence worsened during the year, with an end of year position of 3.6%, and an in month position for March of 4%, which was the highest in month position for many months. An investigation has taken place to assess the reasons for this and it appears that some departments could be more proactive in case-managing long term sickness in particular.

8.7 The cost of sickness absence per employee increased to £1,564, compared to £1,299 the previous year. The HR team are also working more closely with the departments with the highest areas of sickness to ensure that each area is applying the sickness management process effectively.

Mandatory Training

8.8 Mandatory training take up improved slightly to 67%. The Academy is considering grouping the 5 areas of mandatory training reported on the dashboard into a compact training session and/or some e-learning elements, to help improve compliance with mandatory training targets.

8.9 The Health and Safety reporting position has remained at 83% which is encouraging.

Appraisals

8.10 The appraisals rate in March was 72%, compared to 73% the previous month, and the full year position was also 73%. The appraisal policy and training have been reviewed and are due to be re-launched to help increase the quality and take up of appraisal.

Employee Relations

8.11 Local employee relations case management is green. There are a number of complicated cases across various professional groups.

8.12 The Nursery tender is underway with interviews of the two bidders taking place shortly.

Workforce planning

8.13 Workforce planning for staff aged 55 and over is green.

8.14 Job planning for consultant medical staff is still underway with 85% returned so far. A steering group of the Medical Director, Divisional Director and Director of Human Resources has been set up to drive these projects over the next year and beyond.

9 Finance Report (Annex 4)

Key Points

- The pre audited 2011/12 year end income and expenditure position was a surplus of £993,000 before extraordinary items. This represents a favourable variance against the annual budget of £718,000 as detailed in annex 4b.
- An impairment of £600,000 was incurred following revaluation of the Trust's estate including the refurbishment of the Macmillan unit. The impairment is classed as an exceptional item and therefore is excluded from the risk rating calculation.
- The cost improvement target of £4.8 million was achieved in 2011/12 but there was a shortfall in the recurring element of £518,000 which will be carried into 2012/13.
- The cash balance in the bank at the end of March was £6.1 million which was £1.5 million higher than planned due to timing on the capital programme.
- The final risk rating for 2011/12 was 3.2 which is rounded to 3. This was in line with plan.

Income and Expenditure

9.1 The income and expenditure position at the end of March 2012 was a surplus of £993,000 which represents a favourable variance of £718,000 year to date as detailed in annex 4b.

9.2 Private patient income was overachieved by £102,000 in 2011/12 and this was allocated to the cost improvement programme.

9.3 Pay expenditure was £84,000 favourable in month due to vacancies and the year-end position was a £388,000 underspend against all pay areas. Nursing costs were adverse in month by £26,000 which resulted in the year-end position being favourable by £2,000.

9.4 Activity related non-pay expenditure was £722,000 overspent at the end of the year and included within this was drugs costs of £233,000.

Divisional Risks

9.5 **Family Health and Clinical Support:** At the end of month 12 the division was £123,000 overspent against budget but fully achieved their cost improvement target with the exception of the private patient income element which was partially achieved.

9.6 **Surgery:** At the end of month 12 the division was £220,000 overspent against budget but their cost improvement target was achieved in 2011/12 with a shortfall against the non-recurring element of £109,000.

9.7 **Medicine:** At the end of month 12 the division was £360,000 overspent against budget but their cost improvement target was achieved in 2011/12 with a non-recurring element shortfall of £46,000.

Cost Improvement Plan

9.8 The cost improvement programme (CIP) was £4.8 million. This was achieved in year but £518,000 was not achieved recurrently. This has resulted in this balance being added to the plan for 2012/13.

Cash Flow

9.9 The Trust had £6.1 million in the bank at the end of March which was £1.5m above plan. The higher than planned cash balance is mainly attributable to the capital programme underspend as a number of projects commenced later than planned.

9.10 As at 31 March 2012 the Trust's cash investments were as follows:

Investment	Value at 31 March 12	Interest Rate at 31 March 12	Access Terms
Government Banking Service Accounts	£6,921,332	0.25%	Instant
Natwest Main Account	£36,680	0.00%	Instant
Natwest Special Interest	£126,774	0.30%	Instant
Natwest 90 day notice acc	£25	1.30%	Instant (90 day notice expired)
Bank of Scotland	£48,476	0.75%	Instant
Barclays	£2,289		
Less Cash in Transit	(£1,019,795)		
TOTAL	**£6,115,781**		

Capital

9.11 The capital budget for 2011/12 totalled £5.6 million. Expenditure on the 2011/12 capital programme as at 31 March 2012 was £4.2 million. This variance was because some expenditure commenced later than planned. Some of the year's underspend will be used to support the 2012/13 Capital Programme.

9.12 Completed projects in the year include the new combined heat and power plant, the pharmacy/pathology reconfiguration, the refurbishment of the Macmillan Unit, the new equipment library and the upgrade of the booking team's accommodation.

9.13 Projects still in progress include the new birthing pool, new entrance and ground floor clinics in the Women's Health and Maternity Unit, and the new CT scanner.

Financial Risk

9.14 The financial risk rating at the end of March 2012 was 3.2, as shown in the following table:

Metric	Value	Risk Rating	Weighting	Weighted Risk Rating
EBITDA achieved % of plan	115.6%	5	0.50	0.50
EBITDA margin	5.46%	3	0.25	0.80
Return on assets	5.44%	4	0.20	0.80
I&E surplus	0.55%	2	0.20	0.40
Liquidity days	22.56	3	0.25	0.75
Total				**3.2**

10 Recommendation

10.1 The Board of Directors is asked to DISCUSS the performance risks.

List of Annexes

1. Corporate Dashboard – March 2012
2. Quality:
    a. Infection prevention and control: key performance indicators
3. Human Resources:
    a. HR Performance Dashboard
    b. Average estimated cost of sickness
4. Finance:
    a. Executive Summary
    b. Income and expenditure under current contract
    c. Cost improvement summary dashboard
    d. Balance sheet
    e. Cashflow statement
    f. Capital expenditure

Annex 1

STRATEGIC OBJECTIVE	MEASURE	LEAD DIRECTOR	TARGET	THRESHOLDS	1011 YTD	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	1112 YTD
Personal, high quality and safe care																		
To reduce HSMR year on year by 2.5%	Rolling 12 month HSMR	Medical Director	90%	<= 100 - Green >100 but lower confidence limit below 100 - Amber Lower confidence limit above 100 - Red	105.5	103.2	104.4	117.4	114.5	110.1	108.4	106.3	107.1	103.9	100.4			100.4
To ensure that the risk of VTE is minimised	Percentage of patients who need it receiving appropriate VTE (chemical) prophylaxis	Director of Nursing & Clinical Governance	95%	>=95% = Green 85 - <95% = Amber <85% = Red	86%	89%		91%	89%									N/A
	Percentage of patients with completed VTE risk assessment - PAS data submitted to Unify	Director of Nursing & Clinical Governance	90%	>=90% = Green <90% = Red	68.6%	67.8%	64.8%	66.2%	70.4%	69.7%	75.5%	76.2%	68.2%	69.7%	71.0%	89.1%	91.1%	76.5%
To maintain our infection rates at the level of the best 25% of Trusts	Number of 48 hour + MRSA Bacteraemias cases (Rate per 1000 beddays)	Director of Nursing & Clinical Governance	1 per year	0 = Green >=1 = Red	1 (0.01)	0	0	0	0	0	0	0	0	1	1	0	0	2
	Number of 72 hour + Clostridium Difficile cases	Director of Nursing & Clinical Governance	29 per year	0 - <=2 per month = Green 3 = Amber >=4 per month = Red	48	4	1	4	3	1	0	2	2	0	2	2	2	23
	Percentage handwashing compliance	Director of Nursing & Clinical Governance	95%	>=95% = Green 85 - <95% = Amber <85% = Red	92%	87%	89.0%	88.8%	90.6%	92.0%	94.0%	90.0%	94.0%	88.0%	95.0%	90.4%	89.7%	90.5%
Continue to reduce falls by 10% on 10/11 outturn	Number of falls (Rate per 1000 bed days)	Director of Nursing & Clinical Governance	737 (10% decrease on previous year)	<=62 = Green >62 = Red	893 (8.2)	82 (9.4)	71 (7.8)	70 (8.0)	54 (6.3)	92(11.3)	62 (7.9)	49 (6.4)	71 (8.6)	94 (12.1)	60 (6.8)	75 (8.5)		780(8.4)
To ensure that stroke patients receive quick, high quality interventions and appropriate care	Percentage of stroke patients spending 90% of time on stroke ward	Director of Nursing & Clinical Governance	80%	>=80% = Green 60 - <80% = Amber <60% = Red	58.5%	84.4%	62.8%	60.0%	75.9%	78.3%	100.0%	78.3%	86.4%	57.1%	65.0%	81.8%	81.3%	74.7%
	Percentage of high risk TIAs treated within 24 hours	Director of Nursing & Clinical Governance	60%	>=60% = Green 50 - <60% = Amber <50% = Red	56.2%	100.0%	83.3%	61.9%	50.0%	85.7%	83.3%	88.9%	77.8%	60.0%	50.0%	71.4%	88.9%	74.4%
To provide a high quality pathway through the hospital for emergency and elective patients	30day readmission rate -Total readmissions	Director of Operations	<10%	<10% = Green >=10% = Red	5.5% (1.5%)	13.1%	14.2%	13.1%	14.6%	13.4%	16.3%	15.3%	12.6%	13.0%	13.0%	14.9%	13.9%	14.0%
	Delayed transfers of care	Director of Nursing	<=3.5%	<3.5% = Green 3.5 - 5.0% = Amber >5.0% = Red	4.5%	0.3%	2.0%	1.3%	3.0%	3.9%	1.0%	0.7%	0.7%	0.0%	0.0%	3.3%	0.0%	1.4%
	Cancelled Ops - <28day readmission guarantee breaches	Director of Operations	5%	<=5% = Green 5 - 15% = Amber >15% = Red	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
To ensure that privacy and dignity for all patients improves, with an emphasis on the needs of patients with dementia	Implement Dementia Action Plan	Director of Nursing & Clinical Governance		On plan = Green Within one month = Amber Not within plan = Red														N/A
To develop a patient experience strategy based on comprehensive patient feedback on our services	Sample size for exit questionnaires	Director of Nursing & Clinical Governance	Double sample size	within 10% of prev. month = Green 10 - 15% = Amber <15% = Red	77	75	85	85	91	95	127	107	133	69	62	56	76	1061
To ensure that 95% of patients are satisfied or very satisfied with their experience of the hospital	Percentage of patients rating their care as very good or excellent	Director of Nursing & Clinical Governance	95%	>=95% = Green 85%-<95% = Amber <85% = Red	99%	96%	96%	92%	96%	96%	93%	93%	99%	86%	96%	96%	93%	94%
Strong, sustainable services, meeting local needs																		
To achieve 18 weeks consistently in all specialties	18 week wait - Admitted Pathways - 95th Percentile (% achievement)	Director of Operations	23wks (90%)	<=23wks = Green 23wks - 27.7wks = Amber >27.7wks = Red	93.2%	20.3wks (93.5%)	19.6wks (94.4%)	22.3wks (91.9%)	22.4wks (92.1%)	20.4wks (93.9%)	22.9wks (92.3%)	23.0wks (91.4%)	22.0wks (91.9%)	20.9wks (93.2%)	22.8wks (90.8%)	22.1wks (90.8%)	22.5wks (92.2%)	22.1wks (92.1%)
	18 week wait - Non-admitted Pathways - 95th Percentile (% achievement)	Director of Operations	18.3wks (95%)	<=18.3wks = Green >18.3wks = Red	96.7%	16.8wks (96.0%)	16.0wks (97.3%)	17.8wks (95.4%)	17.6wks (96.0%)	17.5wks (96.1%)	17.0wks (96.5%)	16.8wks (96.6%)	17.7wks (95.5%)	17.8wks (95.2%)	17.9wks (95.1%)	17.8wks (95.3%)	15.5wks (96.7%)	17.4wks (96.0%)
	18 week wait - Incomplete Pathways - 95th Percentile (% achievement)	Director of Operations	28wks	<=28wks = Green 28wks - 36wks = Amber >36wks = Red	84.6%	22.4wks (88.4%)	23.7wks (86.6%)	23.7wks (81.3%)	23.7wks (81.3%)	26.4wks (80.9%)	26.3wks (78.9%)	24.9wks (78.5%)	26.5wks (80.5%)	25.9wks (82.2%)	20.5wks (93.3%)	18.0wks (95.0%)	18.5wks (94.6%)	24.5wks (84.2%)
	TOTAL OP Waiting List size	Director of Operations	Size @ March 10	<= 2700 = Green 2701 - 2800 = Amber >2800 = Red	2779	2794	2778	2854	2985	2835	2754	2670	2634	2630	2577	2661	2693	N/A
	No. of >5wk waiters on OP Waiting List	Director of Operations	No. @ March 10	<= 700 = Green 701 - 800 = Amber >800 = Red	832	1092	1046	1168	1176	1132	978	881	832	1017	718	709	811	N/A
	TOTAL IP/DC Waiting List size	Director of Operations	Size @ March 10	<= 2000 = Green 2100 - 2000 = Amber >2100 = Red	1574	1633	1674	1513	1519	1514	1506	1584	1557	1643	1644	1612	1610	N/A
To ensure that patients are seen in a timely way in A&E	4 hour performance (Trust only)	Director of Operations	95%	>=95% = Green 94%-<95% = Amber <94% = Red	96.4%	94.0%	94.7%	96.4%	96.1%	97.2%	97.6%	97.5%	95.9%	96.7%	94.3%	92.9%	97.8%	95.9%
	Total time of 4 hours in A&E (95th Percentile)	Director of Operations	<=4hrs	>4hrs = Red <=4hrs = Green	N/A	4:32hrs	4:15hrs	4:00hrs	3:59hrs	3:59hrs	3:58hrs	3:57hrs	3:59 hrs	3:59 hrs	4:28hrs	4:53hrs	3:58 hrs	4:00 hrs
	Time to Initial Assessment (95th Percentile)	Director of Operations	<=15mins	>15mins = Red <=15mins = Green	N/A	42mins	38mins	30mins	44mins	22mins	28mins	24mins	27 mins	24mins	25mins	30mins	24mins	30mins
	Time to Treatment Decision (median)	Director of Operations	<=60mins	>60mins = Red <=60mins = Green	N/A	1:16hrs	1:09hrs	1:13hrs	1:14hrs	1:08hrs	56mins	50mins	53 mins	45 mins	56mins	1:08 hrs	58mins	1:02 hrs
	Unplanned reattendance rate	Director of Operations	<=5%	>5% = Red <=5% = Green	N/A	3.4%	3.7%	3.5%	3.1%	3.5%	3.5%	3.7%	2.9%	3.8%	2.9%	3.7%	3.8%	3.4%
	Left without being seen rate	Director of Operations	<=5%	>5% = Red <=5% = Green	N/A	2.6%	2.0%	2.7%	2.8%	3.1%	2.2%	1.4%	1.4%	1.8%	2.0%	1.8%	2.1%	2.2%
To ensure that cancer patients receive quick diagnosis and treatment	2 weeks from urgent suspect cancer GP referral to first outpatient appointment	Director of Operations	93%	>=93% = Green 88 - <93% = Amber <88% = Red	94.9%	93.0%	90.4%	93.2%	94.1%	94.9%	93.4%	92.0%	93.9%	93.9%	93.4%	96.1%	93.6%	93.5%
	2 weeks from Urgent GP referral to first outpatient appointment (Symptomatic Breast Patients)	Director of Operations	93%	>=93% = Green 88 - <93% = Amber <88% = Red	93.9%	89.4%	94.1%	97.8%	95.7%	94.4%	94.7%	94.4%	96.4%	100.0%	95.7%	98.1%	97.8%	95.8%
	31 days from decision to treat to start of 1st treatment extended to all cancers	Director of Operations	96%	>=96% = Green 91 - <96% = Amber <91% = Red	98.7%	100.0%	98.2%	98.2%	97.7%	98.5%	100.0%	98.0%	100.0%	100.0%	98.6%	96.5%	98.5%	98.7%
	31 days from decision to treat to start of treatment for subsequent DRUG treatment	Director of Operations	98%	>=98% = Green 93 - <98% = Amber <93% = Red	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	31 days from decision to treat to start of treatment for subsequent SURGICAL treatment	Director of Operations	94%	>=94% = Green 90 - <94% = Amber <90% = Red	99.5%	100.0%	94.1%	100.0%	100.0%	93.3%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.2%
	62 days from all referrals to treatment for all cancers	Director of Operations	85%	>=85% = Green 80 - <85% = Amber <80% = Red	93.7%	93.4%	85.5%	87.7%	85.5%	95.9%	88.8%	87.5%	93.0%	94.1%	95.9%	89.7%	90.1%	91.0%
	62 days from Consultant Screening to treatment for all cancers	Director of Operations	90%	>=90% = Green 85 - <90% = Amber <85% = Red	57.9%	N/A	100.0%	50.0%	100.0%	100.0%	N/A	100.0%	N/A	50.0%	100.0%	100.0%	90.9%	87.9%
	62 days from Consultant Upgrade to treatment for all cancers	Director of Operations	90%	>=90% = Green 85 - <90% = Amber <85% = Red	91.6%	88.2%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%	98.2%

Annex 1

STRATEGIC OBJECTIVE	MEASURE	LEAD DIRECTOR	TARGET	THRESHOLDS	1011 YTD	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	1112 YTD
Our staff are our greatest strength																		
To provide excellent support and development for our staff	Percentage of staff appraised within last 12 months (rolling year)	Director of Human Resources	80%	>80% = Green 65 - 80% = Amber <65% = Red	70%	74%	74%	73%	72%	74%	72%	71%	69%	70%	73%	72%	73%	73%
	Percentage of staff attending mandatory training within last 12 months (rolling year)	Director of Human Resources	85%	>85% = Green 70 - 85% = Amber <70% = Red	68%	67%	66%	65%	65%	63%	65%	64%	66%	64%	65%	66%	67%	67%
To provide management development in those in leadership positions	Number of Human Resources indicators achieved	Director of Human Resources	7	>4 = Green 3 - 4 = Amber <3 = Red	4	3	4	3	4	3	4	4	4	4	4	4	4	4
To develop a strategic workforce plan and succession planning process linked to business plans	Vacancy rate	Director of Human Resources	TBC		3.7%	4.0%	3.7%	4.0%	3.1%	5.0%	4.4%	4.2%	4.1%	4.0%	3.7%	3.4%	3.8%	3.8%
	Total pay costs (Cumulative)	Director of Human Resources	TBC		N/A	£5.9M	£11.9M	£17.9M	£23.8M	£29.8M	£35.8M	£41.7M	£47.7M	£53.5M	£59.5M	£65.7M	£71.5M	£71.5M
	Temporary staff cost (Cumulative)	Director of Human Resources	TBC		£2,776k	£165k	£322k	£490k	£655k	£867k	£1,030k	£1,126k	£1,260k	£1,386k	£1,538k	£1,720k	£1,967	£1,967k
A valued partner in the local health service																		
To maintain market share	GP Referrals Total numbers (% against plan)	Director of Operations	0%	0 - <5% from plan = Green 5 - 10% away from plan = Amber >10% from plan = Red	29883	2173 (-13.6%)	2466 (1.3%)	2467 (-9.1%)	2345 (-12.5%)	2348 (5.1%)	2477 (-2.8%)	2334 (-6.7%)	2457 (3.1%)	2054 (2.1%)	2484 (5.9%)	2524 (1.9%)	2539 (-8.2%)	28676 (-3.2%)
To develop an effective Commercial Strategy	Annual income earned from new sources	Director of Finance										£46.7k	£50.9k	£48.8k	£40.1k	£40.4k	£40.7k	
Managing our money wisely																		
To increase the efficiency of our services by delivering a cost improvement programme of £4.7 million	% of CIP plans in place	Director of Finance	100%	0 - <5% from plan = Green 5 - 10% away from plan = Amber >10% from plan = Red	100%	88%	74%	74%	80%	81%	86%	91%	93%	95%	96.0%	97.0%	100.0%	100.0%
Achieve a financial risk rating of 3	CIP Total Savings (non-recurrent %)	Director of Finance	100%	0 - 5% > plan = Green 5 -10% away from plan = Amber 10% <from plan = Red	100% (14%)	94% (19%)	103% (16%)	113% (10%)	118% (5%)	115% (4%)	123% (17%)	113% (15%)	108% (17%)	106% (11%)	104% (4%)	99% (6%)	100% (12%)	100% (12%)
	Financial risk rating	Director of Finance	3	> 3 = Green 2.5 - 3 = Amber <2.5 = Red	3.6	3.2	2.7	2.7	3.4	2.7	2.7	3.2	3.2	2.8	3.0	3.3	3.2	3.2
	RoA (YTD)	Director of Finance	5.2%	>=5.2% = Green 4.0 - 5.1% = Amber <4.0% = Red	5.0%	4.3%	3.2%	3.1%	3.2%	3.2%	3.3%	3.7%	3.8%	3.2%	3.7%	3.5%	3.9%	3.9%
	Liquidity Ratio	Director of Finance	25	>25 = Green 15-25 = Amber <15 = Red	26.9	24.4	22.4	23.2	25.6	23.5	23.4	25.3	25.5	24.8	24.7	25.4	22.4	22.4
	PbR Income performance (£) YTD	Director of Finance	0	>0 = Green -£150,000k - 0 = Amber <-£150,000k = Red	-1,062,000		-£186,000	-£96,000	-£280,000	£145,000	-£77,000	-£230,000	£335,000	£153,000	£522,000	£715,000	-£170,000	-£170,000
To reduce readmission rates	PBR 30 day Readmission rate - Post-elective	Director of Operations	TBC		N/A	2.4%	2.9%	2.7%	3.0%	2.5%	3.2%	4.2%	1.8%	3.0%	3.0%	3.5%	3.0%	2.9%
	PBR 30 day Readmission rate - Post-emergency	Director of Operations	TBC		N/A	10.7%	11.3%	10.4%	11.7%	10.9%	13.1%	11.1%	10.8%	9.9%	10.0%	11.3%	10.9%	11.0%
To deliver a surplus of £0.3M for investment in our buildings	I&E Surplus (YTD)	Director of Finance	1%	>1% = Green 0.0 - 1.0% = Amber <0.0% = Red	1.0%	1.2%	-1.4%	0.4%	1.6%	0.2%	0.5%	0.9%	0.3%	0.2%	0.6%	0.8%	0.7%	0.7%
	I&E position - variance from plan (YTD)	Director of Finance	On plan			£4,000	-£68,000	-£159,000	-£134,000	-£95,000	-£63,000	-£61,000	-£60,000	£32,000	£85,000	£113,000	£718,000	£718,000
	EBITDA (% of Plan Achieved)	Director of Finance	100%	>100% from plan = Green 85 - 99% = Amber <85% = Red	87.7%	102.6%	89.9%	89.4%	94.7%	94.3%	92.0%	99.1%	99.2%	102.2%	103.0%	103.4%	115.6%	115.6%
	EBITDA margin %	Director of Finance	5.9%	>5.9% = Green 4.0 - 5.8% = Amber <4.0% = Red	5.3%	5.9%	3.3%	4.9%	6.1%	4.7%	5.0%	5.5%	5.0%	5.0%	5.2%	5.1%	5.5%	5.5%
Infrastructure that supports delivery																		
To open the refurbished MacMillan Unit	Project progress against plan and budget	Director of Estates & Facilities		On plan = Green Within one month = Amber Not within plan = Red								Unit open	N/A	N/A	N/A	N/A	N/A	
IT strategy	Project progress against plan and budget	Director of Planning and Performance		On plan = Green Within one month = Amber Not within plan = Red	N/A													
Estates strategy	Project progress against plan and budget	Director of Estates & Facilities		On plan = Green Within one month = Amber Not within plan = Red	N/A													

Annex 1

Dr Foster rebased HSMR benchmarks in June leading to a shift in expected values.

New audit data to be taken from Nursing Documentation starting from Oct 11. Reporting start delayed until Nov 11.

Reported a month in lieu.

Data unavailable for Mar.

NOTE: changed from 28 to 30 day and matched to new 2011/12 Technical Guidance

2011/12 - monthly SITREP snapshot (based on last Thursday in reporting period)

Annex 1

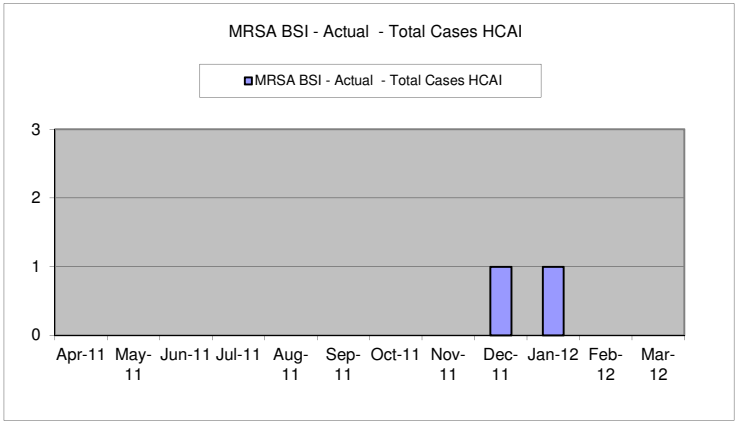
Referrals plan has been adjusted to account for the removal of the Pain Service.

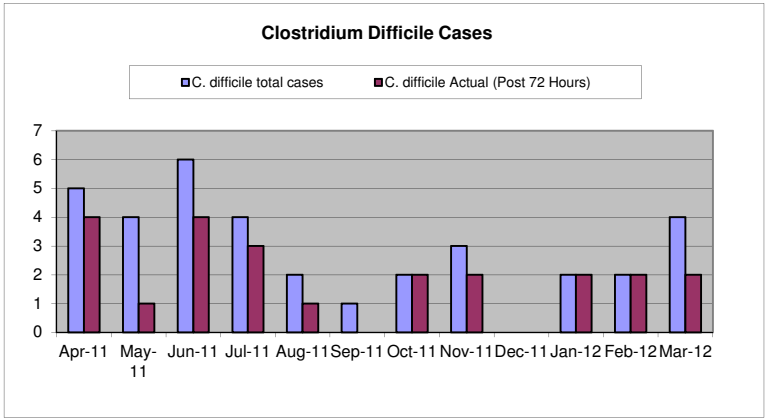
Infection Prevention and Control
Key Performance Indicators 11/12

Date of Report Mar-12

Annex 2a

Numbers	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Mar-12**	**Annual Target**
C. *difficile* total cases	5	4	6	4	2	1	2	3	0	2	2	4	
C. difficile Actual (Post 72 Hours)	4	1	4	3	1	0	2	2	0	2	2	2	**29 post**
Compliance													
MRSA elective screening - Trust wide Compliance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	TBC	
MRSA Emergency Screening - Trust Wide Compliance	91%	92%	89%	91%	87%	89%	91.30%	91%	92%	94%	92%	TBC	
MRSA Long Stay Screening - trust wide compliance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Side Room isolation -Trust Wide Compliance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Numbers	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Mar-12**	**Annual Target**
MRSA BSI - Actual - Total Cases HCAI	0	0	0	0	0	0	0	0	1	1	0	0	**1**
MSSA BSI HCAI Total Cases	0	2	2	1	0	0	1	0	0	0	1	0	**-**



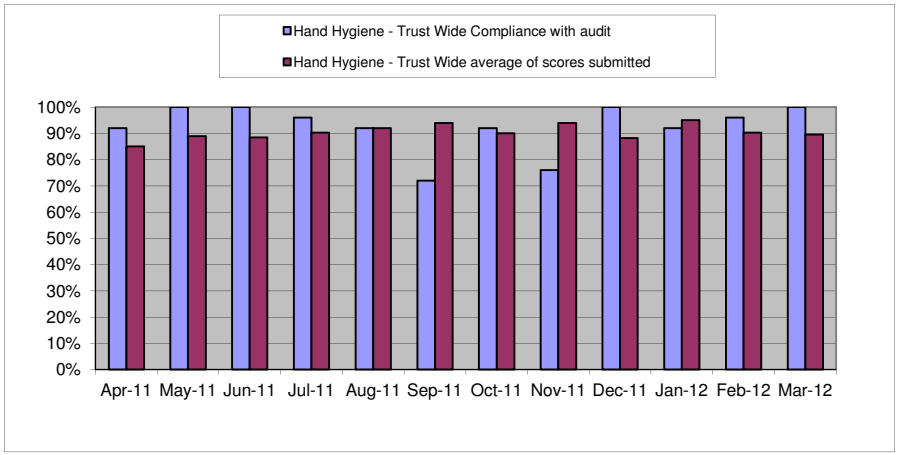


Numbers	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Jan-12**	**Feb-12**	**Mar-12**	**Annual Target**
Hand Hygiene - Trust Wide Compliance with audit	92%	100%	100%	96%	92%	72%	92%	76%	100%	92%	96%	100%	100%
Hand Hygiene - Trust Wide average of scores submitted	85%	89%	89%	90%	92%	94%	90%	94%	88%	95%	90%	90%	95%-100%

Areas of non-compliance with undertaking hand hygiene
N/A

Areas where hand hygiene score was below 95%:	Dr	Nurse	Other	Compliance score
8A	83%	90%	67%	80%
8B	0%	87%	40%	65%
7A	89%	89%	67%	84%
6B	100%	100%	0%	80%
ICU	100%	92%	100%	94%
ED	67%	100%	n/a	90%
X-ray	78%	100%	0%	59%
Main OPD	80%	44%	n/a	63%
SCBU	100%	100%	67%	91%

If no data submitted then no staff audited from that group



FINANCE REPORT FOR MARCH 2012
EXECUTIVE SUMMARY

BUDGET PERFORMANCE

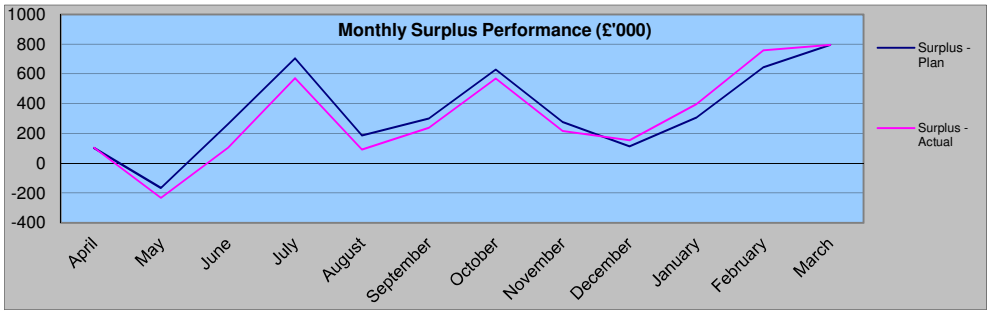
	Budget	YTD Actual	Variance
Income	109,021	109,022	2
Pay	(71,927)	(71,539)	388
Non Pay	(31,373)	(30,969)	404
EBITDA	5,721	6,514	794
Other	(5,269)	(5,719)	(450)
Surplus	**452**	**795**	**343**
Surplus for FRR	**275**	**993**	**718**

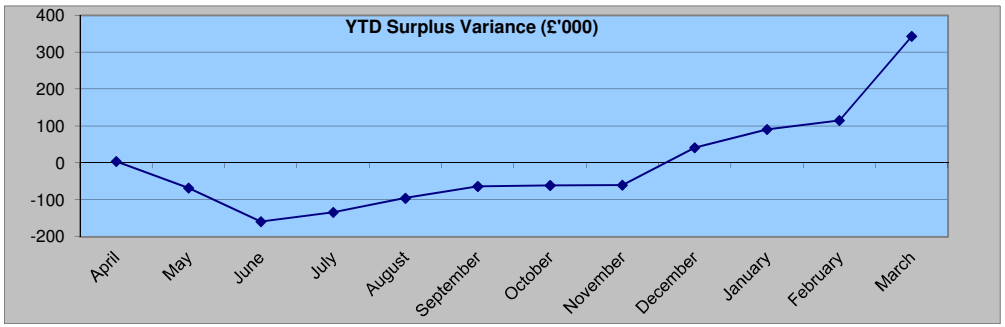
EBITDA % Plan	113.9%
EBITDA Margin %	6.0%
Surplus % Plan	175.9%
Surplus %	0.7%

FINANCIAL RISK RATING

EBITDA % of plan	5
EBITDA margin	3
Return on Assets (Forecast)	4
I&E Surplus	2
Liquidity	3
Total Weighted FRR	**3.2**

SURPLUS PERFORMANCE





CASH

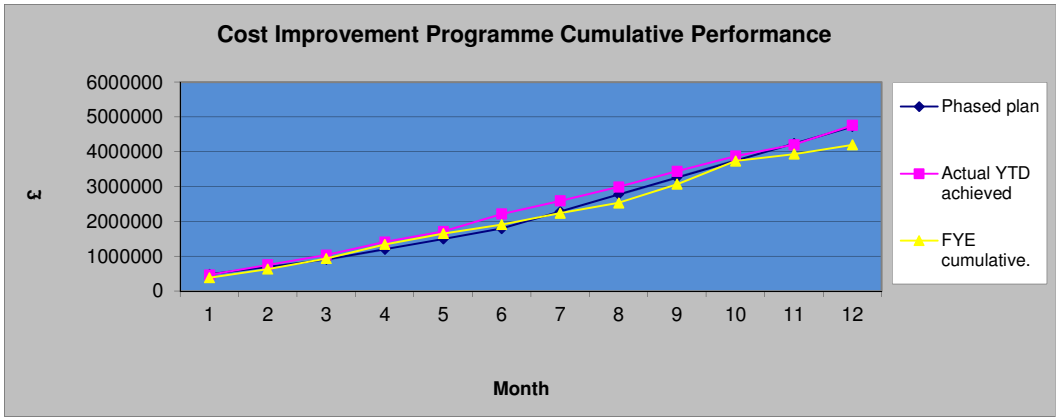
Cash Balance	6,118
Cash more than Plan by	1,494
Forecast - 12 Month Cash	6,358

CAPITAL

Capital YTD Spend	4,199
Spend YTD less than Plan by	1,412
Annual Plan	5,610

CIP

CIP - Achieved YTD	4,765	Recurrent	4,252
Annual Target	4,765		



COMMENTARY

Key issues Commentary

At Month 12 the year to date variance is £718,000 favourable against plan.

Annex 3b

Average estimated cost of sickness per person - 2011/12 and 2010/11

2011/12						
Medicine, Emergency and Pharmacy Division	**Feb12 Sickness Costs**	**Feb12 No. of sick staff**	**Av. Sick Costs per person**	**YTD Sickness Costs**	**YTD No. of sick staff**	**YTD Av. Sick Costs per person**
Emergency Department	9,520	18	529	98,045	61	1,607
Medicine Directorate	21,380	53	403	285,203	263	1,084
Pharmacy	2,434	9	270	18,692	33	566
Division Total	**33,334**	**80**	**417**	**401,939**	**357**	**1,126**
Orthopaedics, Surgery and Critical Care Division	**Feb12 Sickness Costs**	**Feb12 No. of sick staff**	**Av. Sick Costs per person**	**YTD Sickness Costs**	**YTD No. of sick staff**	**YTD Av. Sick Costs per person**
Critical Care Directorate	11,236	37	304	255,317	183	1,395
Orthopaedic Directorate	5,480	18	304	76,745	86	892
Surgical Directorate	12,429	31	401	90,949	108	842
Therapists	4,528	11	412	42,079	51	825
Division Total	**33,673**	**97**	**347**	**465,090**	**428**	**1,087**
Family and Diagnostics Division	**Feb12 Sickness Costs**	**Feb12 No. of sick staff**	**Av. Sick Costs per person**	**YTD Sickness Costs**	**YTD No. of sick staff**	**YTD Av. Sick Costs per person**
Cancer Services Directorate	2,887	4	722	12,069	17	710
Child Health Directorate	8,053	14	575	76,827	69	1,113
Gynaecology Directorate	5,873	10	587	53,081	41	1,295
Maternity Unit	18,632	29	642	112,230	83	1,352
Operations Directorate	2,009	7	287	42,602	67	636
Pathology Services	2,668	9	296	21,983	34	647
Radiology Directorate	3,370	11	306	65,001	41	1,585
Division Total	**43,493**	**84**	**518**	**383,792**	**352**	**1,090**
Corporate Services	**Feb12 Sickness Costs**	**Feb12 No. of sick staff**	**Av. Sick Costs per person**	**YTD Sickness Costs**	**YTD No. of sick staff**	**YTD Av. Sick Costs per person**
Estates & Facilities Management	12,525	32	391	128,748	126	1,022
Finance & Other Services	2,540	5	508	36,970	36	1,027
Management Services	2,806	8	351	123,269	61	2,021
Nurse Administration	1,502	4	375	11,157	24	465
Yeovil Academy	2,499	5	500	13,876	14	991
Corporate Services Total	**21,872**	**54**	**405**	**314,019**	**261**	**1,203**
Trust Total	**132,371**	**315**	**420**	**1,564,841**	**1,398**	**1,119**

2010/11			
Medicine, Emergency and Pharmacy Division	**YTD Feb11 Sickness Costs**	**YTD Feb11 No. of sick staff**	**YTD Feb11 Av. Sick Costs per person**
Emergency Department	36,754	69	533
Medicine Directorate	247,461	256	967
Pharmacy	5,015	25	201
Division Total	**289,230**	**350**	**826**
Orthopaedics, Surgery and Critical Care Division	**YTD Feb11 Sickness Costs**	**YTD Feb11 No. of sick staff**	**YTD Feb11 Av. Sick Costs per person**
Critical Care Directorate	233,812	180	1,299
Orthopaedic Directorate	84,588	76	1,113
Surgical Directorate	82,212	108	761
Therapists	20,964	51	411
Division Total	**421,576**	**415**	**1,016**
Family and Diagnostics Division	**YTD Feb11 Sickness Costs**	**YTD Feb11 No. of sick staff**	**YTD Feb11 Av. Sick Costs per person**
Cancer Services Directorate	5,060	13	389
Child Health Directorate	75,181	69	1,090
Gynaecology Directorate	61,713	51	1,210
Maternity Unit	134,510	83	1,621
Operations Directorate	32,758	68	482
Pathology Services	25,694	28	918
Radiology Directorate	56,431	38	1,485
Division Total	**391,347**	**350**	**1,118**
Corporate Services	**YTD Feb11 Sickness Costs**	**YTD Feb11 No. of sick staff**	**YTD Feb11 Av. Sick Costs per person**
Estates & Facilities Management	94,386	117	807
Finance & Other Services	24,935	33	756
Management Services	57,999	62	935
Nurse Administration	11,356	21	541
Yeovil Academy	8,455	13	650
Corporate Services Total	**197,132**	**246**	**801**
Trust Total	**1,299,285**	**1,361**	**955**

Yeovil District Hospital NHS
NHS Foundation Trust

Report to: Board of Directors

Report from: Chair of Non-Clinical Risk Assurance Committee

Subject: **Assurance Report**

Date: 16 May 2012

SUMMARY
The following is a summary for the Board of Directors of the issues discussed at the meeting on 15 May 2012 of the Non-Clinical Risk Assurance Committee.

1. Trust Workforce Plan – Our Staff - AF 3.1
The Committee was briefed by Alison Rayner on the HR Department's need for a forecasting and modelling tool to assist with the tracking and management of salary costs. Pippa Moger informed the Committee that work was in hand on such a tool that would track the three main metrics of Finance, Quality and Workforce. The suitability of the model already in use at Taunton & Somerset would also be analysed. NCRAC recommends that this risk be rated **Amber-Green**. 

2. Draft Annual Report
The draft for auditors of the Annual Report version 3.1 was reviewed by the Committee. Assurance was sought from RSM Tenon that they would follow-up and confirm that the range of actions to support assurance and reduce risk outlined in the section headed 'Our Major Risks' was being implemented.

3. Contract Performance Strong - Sustainable Services - AF 2.2
The Committee was briefed by Pippa Moger on various aspects of the 2012–2013 Contract Performance including potential rewards, inherent risks and Trust roles, responsibilities and reporting lines. It was noted that Best Practice and CQUIN rewards could amount to £2.1m in 2012 which, if earned, would then automatically be included in 2013-2014 budgets. However the risk of penalties for underperformance in areas such as RTT, C diff, cancer targets, ambulance handover and readmissions (amongst others) could quickly outweigh even the highest level of rewards. The Committee agreed that it was vital that a wide-spread awareness of the existence of these penalties should be promoted at every level throughout the Trust. NCRAC recommends that this risk be rated **Green**. 

4. Information Systems – Infrastructure that supports delivery – AF 6.2
The Committee received good assurance from Jeremy Martin and Richard Hale concerning progress being made with the development and implementation of a fully integrated Electronic Health Record (EHR). However a delay of up to six months is now expected as a result of a new initiative to secure funding out of the remaining capital from the National Programme for IT. This would entail a Board decision for the Trust to join a procurement consortium with two other hospitals. The potential risks to the successful completion of the programme were defined as a combination of a failure to secure funding, a failure between the three participants to agree on common systems and a lack of resource to implement the scheme. NCRAC recommends that this risk be rated **Amber-Green**. 

5. Recommendation
The Board of Directors is asked to DISCUSS and AGREE the assurance recommendations from NCRAC.

Yeovil District Hospital NHS
NHS Foundation Trust

To: **Board of Directors**

From: **Director of Nursing & Clinical Governance**
Director of Operations

APPENDIX 10
BOARD OF DIRECTORS
16 MAY 2012

Subject: Night Discharge Arrangements

Date: 16 May 2012

1. INTRODUCTION

1.1. Further to a freedom of information request, that resulted in the publication of the number of overnight discharges from NHS Trusts the Board of Directors sought assurance that inpatients are not discharged after 11pm and before 6am.

2. FINDINGS

2.1. Patient discharges are recorded on the Patient Administration System (PAS) this has historically been kept up to date by ward clerks. With the introduction of SwiftPlus, nurses now keep this data up to date. However, the Trust is still a long way from achieving a live PAS.

2.2. Discharges can be measured in real time, but only if they are entered in real time, current practice is for night staff to correct the computer once all patients have settled for the night rather than complete this in real time. At this stage data cannot be provided for assurance.

2.3. The Trust does not have a policy of discharge at night, community hospitals do not accept patients late in the evening and the Clinical Site Managers were able to confirm that patients are not discharged at night.

2.4. Complaints were reviewed over the last 12 months and there were 2 complaints, however these were both from the Emergency Department and not from inpatient areas. The Emergency Department complaints resulted in improvements in the support available to vulnerable patients who are returning home from the Emergency Department during the night.

3. SHORT TERM ACTIONS

3.1. In the absence of a live PAS discharges at night will be reported as a clinical incident. Any incident can then be reviewed to confirm whether the discharge was either the patients choice or in their best interests. This process mirrors what happens for any Mixed Sex Accommodation breach.

4. LONG TERM ACTION

4.1. A transformation project lead to be allocated to complete the SwiftPlus live PAS project. Real time bed information will then be available.

The Board of Directors is asked to **NOTE** the position with regard to discharges at night.

Yeovil District Hospital NHS
NHS Foundation Trust

To: **Board of Directors**

From: **Director of Nursing & Clinical Governance**

APPENDIX 9
BOARD OF DIRECTORS
16 May 2012

Subject: Nutrition Update

Date: 16 May 2012

1. INTRODUCTION

1.1. Further to the Associate Directors of Nursing Privacy Dignity Nutrition and Hygiene, report (March 2012), it was agreed to provide the Board of Directors with an update on the work to improve Nutrition within the Trust.

1.2. Ensuring patients are well nourished and adequately hydrated whilst in hospital can be challenging, however this goal is an element of essential nursing care and an indicator of the overall standard of nursing care provided for patients.

2. HOW WE MEASURE

2.1. Given the concerns raised by the Patients Association nationally the CQC conducted a series of DANI (Dignity and Nutrition inspections), whilst the Trust was not inspected the Director of Nursing was a DANI inspector. We used this information to conduct our own mock DANI inspections on 2 wards, results were encouraging and have informed the work of the nutrition steering group.

2.2. Every patient has a Nutrition Assessment using the MUST tool, and Matrons are auditing 5 sets of nursing records monthly using Snap Surveys.

2.3. The CQC's unannounced inspection found good practice in relation to nutrition.

2.4. Root cause analysis investigations of pressure ulcers have highlighted the link to nutrition and wards with high levels of risk have been able to act on these findings and implemented build up rounds.

2.5. The Patient and Public Involvement forum have completed Observations of care at mealtimes and this information has been used at peer review and at the Patient Environment action group.

3. IMPROVEMENTS IMPLEMENTED

3.1. Patient have benefited from the Board of Governors work into locally sourced food. Soup for the evening meal uses local produce they are prepared on site to the chefs recipe and are both high calorie and high protein. A choice of hot fork food has also been added to the evening meal.

3.2. New breakfast trolleys have been implemented, the full benefit is yet to be realised and this is work in progress.

3.3. Matrons and Sisters are working to ensure standards regarding protected mealtimes are maintained and well communicated, and the PPI volunteers will continue a programme of mealtime observations.

3.4. Dementia befrienders have been recruited; these volunteers will help at mealtimes. Red mugs have been implemented to support patients with dementia.

4. FURTHER WORK

4.1. The Nutrition Steering group are focusing improvement on one ward with the aim to roll out through Nutrition champions on all wards.

4.2. A 6 month intensive education programme for nursing staff on the use of the MUST tool and a revised version of the MUST tool.

The Board of Directors is asked to **NOTE** the progress being made with regard to Nutrition.

FINANCE REPORT FOR MARCH 2012
EXECUTIVE SUMMARY

BUDGET PERFORMANCE

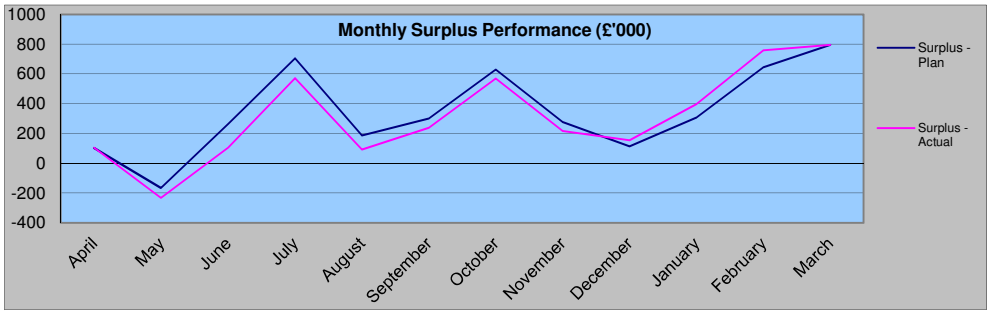
	Budget	YTD Actual	Variance
Income	109,021	109,022	2
Pay	(71,927)	(71,539)	388
Non Pay	(31,373)	(30,969)	404
EBITDA	5,721	6,514	794
Other	(5,269)	(5,719)	(450)
Surplus	**452**	**795**	**343**
Surplus for FRR	**275**	**993**	**718**

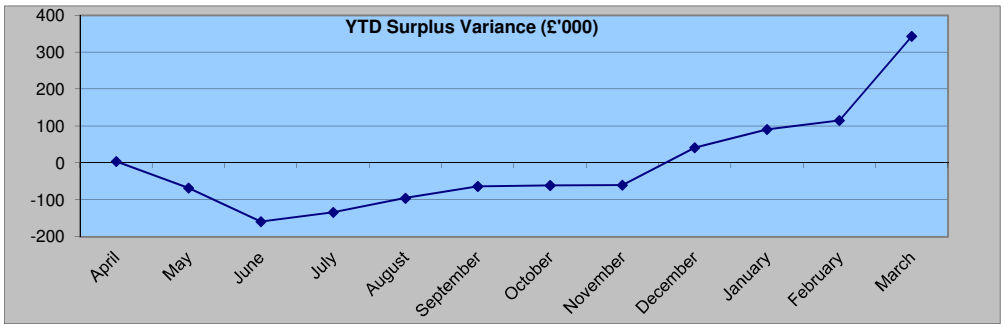
EBITDA % Plan	113.9%
EBITDA Margin %	6.0%
Surplus % Plan	175.9%
Surplus %	0.7%

FINANCIAL RISK RATING

EBITDA % of plan	5
EBITDA margin	3
Return on Assets (Forecast)	4
I&E Surplus	2
Liquidity	3
Total Weighted FRR	**3.2**

SURPLUS PERFORMANCE





CASH

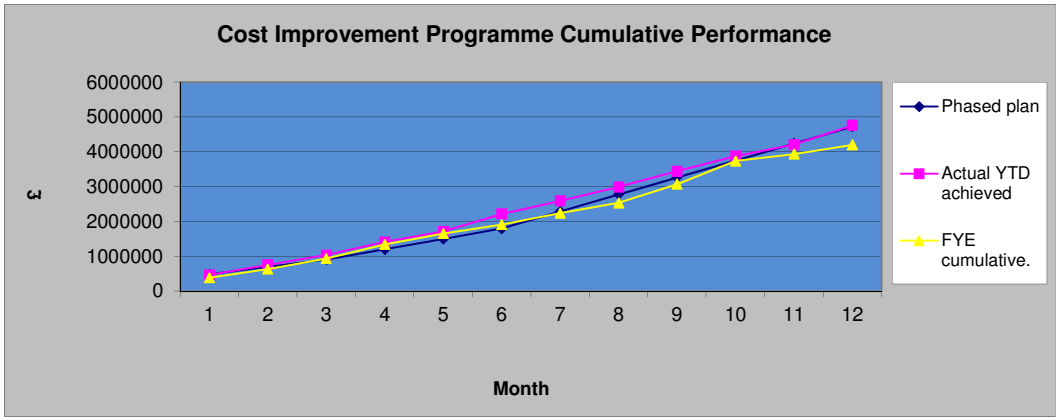
Cash Balance	6,118
Cash more than Plan by	1,494
Forecast - 12 Month Cash	6,358

CAPITAL

Capital YTD Spend	4,199
Spend YTD less than Plan by	1,412
Annual Plan	5,610

CIP

CIP - Achieved YTD	4,765	Recurrent	4,252
Annual Target	4,765		



COMMENTARY

Key issues Commentary

At Month 12 the year to date variance is £718,000 favourable against plan.

Yeovil District Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors	APPENDIX 7 BOARD OF DIRECTORS 16 May 2012
Report from:	Director of Planning & Performance	
Subject:	Performance Report	
Date:	16 May 2012	

1 Introduction

1.1 This report sets out an overview the performance of the Trust during the month of March 2012. It provides a summary of performance in key areas, and highlights the main risks and issues.

1.2 The report is structured as follows:

- Performance overview and key points from the corporate dashboard
- Separate sections setting out more detail on performance in the four key areas of:
  - quality and patient experience;
  - service delivery;
  - human resources
  - finance.

2 Performance Overview

2.1 This section highlights the key points within the performance report for the Board's attention:

- The rolling 12-month Hospital Standardised Mortality Ratio (HSMR) has now fallen to 100.4, down from 117.4 when rebased in June.
- There were two C difficile cases in March which brought the year-end position to 23, against a year end maximum number of 29.
- Performance against the 4 hour A&E standard was 97.8% in March, bringing the quarter four position to 95.08%.
- Despite fears that the work to reduce the waiting list to achieve a maximum 18 week admitted wait in all specialities would mean that the Monitor standard was not achieved in quarter four, the 95th percentile wait was 22.5 weeks, which was within the target of 23 weeks.
- The Trust is an outlier for slot availability through the Choose and Book system for outpatient appointments. The most recent performance data indicates that for 22% of the patients who attempted to book an appointment at YDH there were no available slots to book into.
- Financial performance improved again and stood at £718,000 ahead of plan at the end of March, with a surplus of £993,000.
- The Trust was Green against the governance element of the Monitor Compliance Framework.

3 April Position

3.1 This report focuses on performance in March 2012, and is based on the dashboard for the year 2011/12. Some performance data for April was available at the time of writing, and the key points were:

- 95.0% of patients were seen within 4 hours in the emergency department
- Unvalidated data suggests that the 18 weeks referral to treatment target was achieved for both admitted and non-admitted patients, although not in all specialities.
- There were no C difficile or MRSA cases in April.

4 Corporate Dashboard (Annex 1)

4.1 The main tool by which the Board receives assurance on the Trust's performance is the Trust's dashboard. This contains the key targets which the Trust is required to meet by the Department of Health or its commissioners. This report is the last based on the dashboard for the year 2011/12. A revised dashboard will be in place for 2012/13.

4.2 This section highlights key risks or issues within the corporate dashboard:

Personal, high quality and safe care

- Objective: Reduce HSMR year on year by 2.5%: Dr Foster carried out the annual rebasing of their HSMR figures in September with the result that the rolling 12 month HSMR increased to 117.5. This has now fallen back to 100.4 which is closely in line with the Trust's expected rate of 100. Reviews of notes in key areas continually demonstrate that the Trust provides a high quality of care. Changes have been made to the recording of patient allocation to consultants on the PAS system which has reduced the number of episodes per spell to levels in line with other trusts, and should have a positive impact on our HSMR. The new coding software went live in January, which is also expected to improve our position, along with the continuing work programme of the Dr Foster Steering Group.
- Objective: Maintain low infection rates: There were two C. difficile cases in March so the end of year total was 23, which was below the maximum target number of 29.
- *Objective: High quality stroke care:* Performance against both stroke indicators has been inconsistent during the year; however, both the stroke ward and TIA targets were achieved in February and March. The NHS Institute has been working with the team to redesign the pathway within the Trust in order to enable consistent achievement of both targets.
- Objective: High quality patient pathway: The readmission indicator has been red since April 2011. This was discussed at the December Hospital Management Team meeting and an action plan is being implemented to address the issues around recording, contract negotiations, and to ensure there are no clinical issues of concern, although it needs to be closely monitored to ensure performance improves.

Strong, sustainable services, meeting local needs

- Objective: Waiting times: All three of the new waiting time indicators were achieved, despite concerns that the overall admitted target would be missed due to reducing the number of longer waiters. From April, these indicators will need to be achieved at speciality level and work is in progress to achieve this over a four month period.
- Objective: A&E waits: Performance in February against the 4 hour standard was 92.9%. Performance improved significantly in March, and the position for the quarter was 95.08% which meant that the quarterly Monitor governance rating requirement was achieved.
- Objective: Cancer waits: All cancer targets were achieved in March.

Our staff are our greatest strength

- Performance in March was consistent with previous months. Appraisal and mandatory training rates are static at around 73% and 67% respectively. Further work is being undertaken to improve them.

A valued partner in the local health service

- GP referrals were above plan in four out of the last five months, but below plan in March. The full year performance in respect of GP referrals was 3.2% below plan.

To manage our money wisely

- Objective: Achieve a financial risk rating of 3: The Trust position improved from £113,000 above plan to £718,000 above plan for income and expenditure at the end of March. 100% of cost improvement plans were in place at the end of March.

Infrastructure to support delivery

- Progress is on track against the Estates Strategy, and the IT Strategy has been relaunched. Procurement of major new hospital systems has now commenced.

5 Monitor Compliance Framework

5.1 The Trust achieved a Green rating for governance in quarter three. 18 weeks admitted performance, and 4 hour performance were risks for quarter four. After much hard work by many staff, both were achieved at the end of March, which has resulted in a governance rating of Green for quarter four.

6 Clinical Quality and Patient Safety (Annex 2)

Key Points

- The year-end C difficile target was achieved, with 23 cases against a maximum target of 29
- There were two cases of MRSA during the year, exceeding the Trust's contractual target of 1, but well within the governance framework requirements set by Monitor
- The hospital's Standardised Mortality Ratio (HSMR) continues to fall and has been below 100 for 6 months.
- Performance against the internal targets to reduce falls and pressure ulcers are behind plan.

Clinical Quality

6.1 There were two C. difficile cases in March which brought the year-end total to 23, well below the maximum target number of 29.

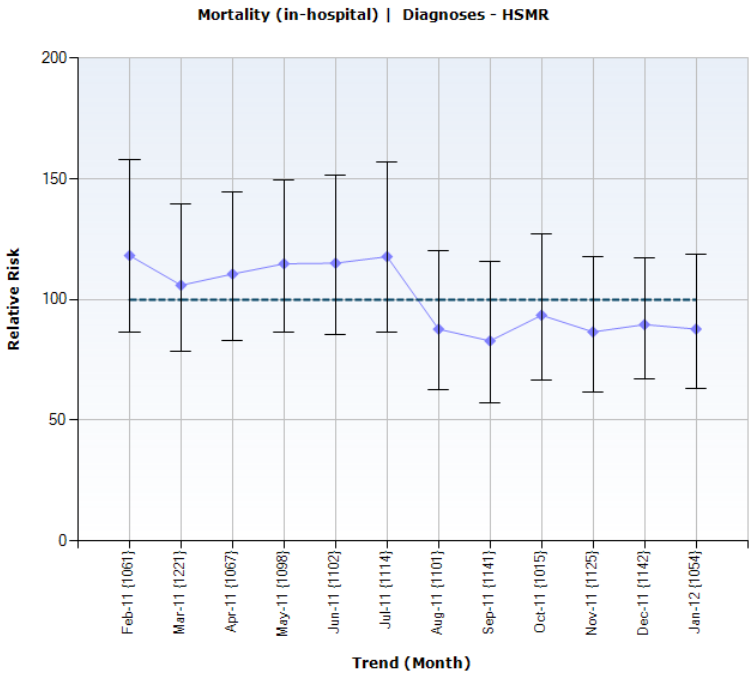
6.2 There were no MRSA cases in March, which left the total for the year unaltered at two cases, one of which was a contaminated sample. The Trust's contractual maximum of one case was exceeded, but the level was well below the de-minimis level of 6 set by Monitor in its Compliance Framework.

6.3 The infection prevention and control key performance indicators, which provide more detail, are attached at annex 2a.

6.4 The Hospital Standardised Mortality ratio (HSMR) for the most recent rolling 12 months was 100.4, and the in-month figure for January was 87.8. The HSMR has been below 100 for six successive months.

6.5 The new Department of Health Summary Hospital-level Mortality Indicator (SHMI) is 108.6 (July 2010- June 2011), which is within expected limits for a trust this size.

6.6 The chart below shows the trend in the Trust's HSMR over the last year.



6.7 The target to ensure that 90% of patients are assessed for VTE risk and are recorded as such on PAS was achieved for the first time in March.

6.8 Performance against the key internal patient safety targets for the year to the end of February is summarised below. It should be noted that due to the lag in reporting of incidents, the data for incident reports is one month in arrears.

	February data	**YTD data**	**YTD target**	**Variance (%)**	**Full year target**
VTE - % patients with completed risk assessment	91.1%	76.5%	90% (March)	+1.1%	90%
Patient safety incidents reported	212	2530	2329	+ 201 (+8%)	2541
Patient Falls	73	778	759	+ 19(+2%)	828
Rate per 1,000 bed days	8.29	8.43	6	Above target	6
Percentage falling more than once	24%	25%	25%	On target	25%
Hospital acquired pressure ulcers (grade 2 and above)	13	169	8 (in-month target for February)	+5 (+19%)	26 in quarter 4
Rate per 1,000 bed days	1.48	1.82	1.5	February Year to date	1.5
Root Cause Analysis investigations (March)	4	78	54	On target	54

6.9 Four new root cause analysis reviews were commissioned in March; one related to a patient undergoing an MRI scan despite the presence of a pace-maker, two patients fell and sustained fractures (one wrist and one cervical spine) and one case reported the misinterpretation of radiology results.

6.10 A total of 14 remain open and under investigation, and the themes identified in these open reviews are as follows:

- 2 falls resulting in a fracture
- 7 concerns about clinical treatment
- 1 hospital acquired pressure sores Grade 3 and above
- 1 retained dental screw (Never Event)
- 1 unexplained death
- 2 misinterpretation of investigation results

6.11 A number of actions have been completed as a result of completed investigations, including:

- Further education in the monitoring and documentation of pressure sores
- Development of a policy for patient transfer
- Use of South West Peninsular Critical Care Transfer forms

- Introduction of new nursing documentation
- Continued development of care bundles
- Ongoing review of all deceased patients' records
- Audit of practices in place in delivery rooms in respect of swab counts

6.12 The Trust uses an early warning tool called the Swiss Cheese to detect an early signs of potential patient safety in issues within clinical areas. This tool has been adopted across the South West region and is being used in all acute trusts.

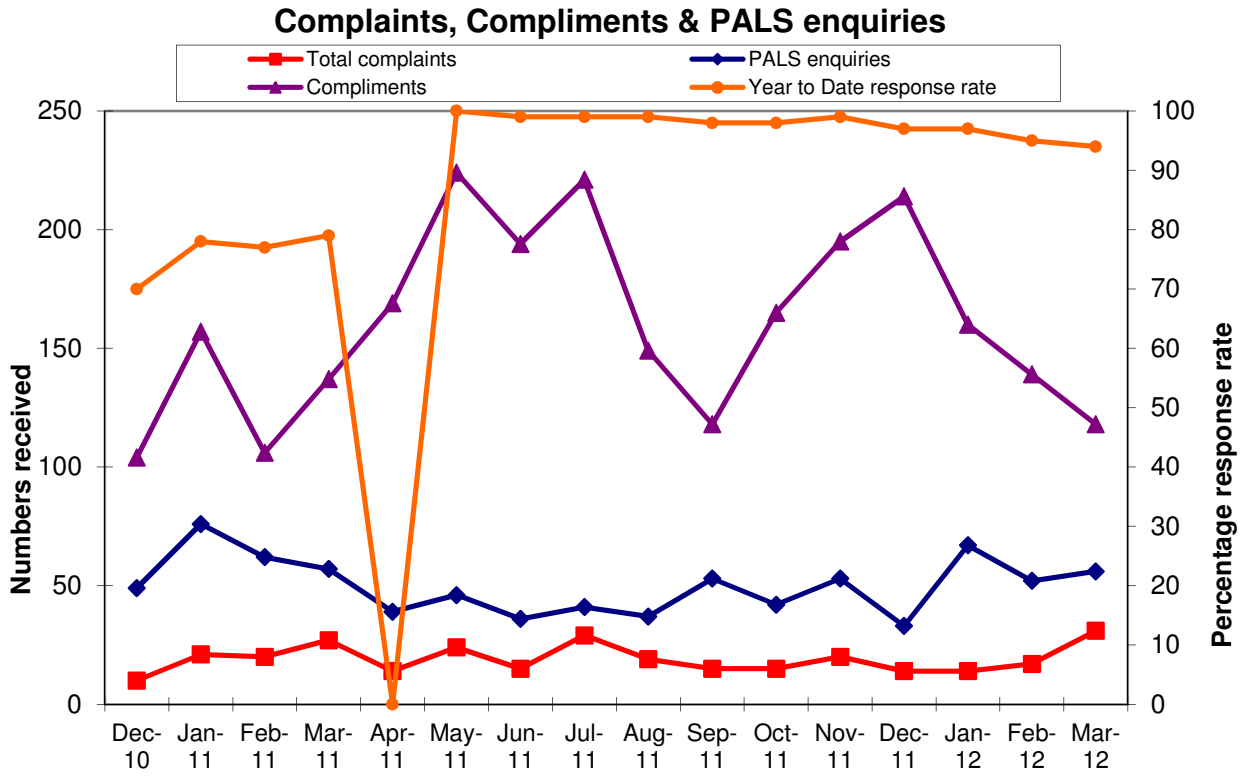
6.13 The indicators describe the most important conditions necessary for a well-functioning team. The tool prompts staff to make a judgement against the key indicators and then it automatically weights and scores them according to their importance. An overall score of more than 12 indicates that remedial action needs to be taken to prevent a later impact on the quality of care provided within that area. Each clinical area's assessment is reviewed by peers from another area to ensure consistency and a robust approach.

6.14 In February two areas were rated amber (scores between 9 and 11): the emergency admissions unit and the Kingston Wing. Two areas were rated red: the emergency department and ICU with scores of 12. 7 areas did not report, which was unusually high. The remaining 14 were green.

6.15 The Trust was subject to an unannounced inspection by the Care Quality Commission on 22 March. This was part of a national programme of reviews of all organisations licenced to perform termination of pregnancies and focused on compliance with the legislation. Initial feedback was positive, with the inspector confirming that our pathway and practice comply with the legislation; however, some of our record keeping was incomplete and could be improved. The inspector commented on the good care our patients receive.

Patient Experience

6.16 Patient complaints and concerns raised via the Patient Advice and Liaison Service continue to provide the Trust with valuable insight into the patient experience. This should be considered in conjunction with the data available from patient surveys, including national, Your Care and EXIT surveys. The following chart shows the trend data in respect of complaints, PALs enquiries and compliments.



6.17 The overview information in respect of in-house patient satisfaction surveys is outlined in the table below :

	March data	**YTD data**	**YTD target**	**Variance (%)**	**Full year target**
Your Care surveys completed	151	1799	1958	-159(8%)	2136
Overall care rated excellent	56%	65%	80%	Below target	80%
Staff attitude rated as excellent	62%	69%	80%	Below target	80%
Bathroom cleanliness rated as excellent	85%	82%	80%	Achieved target	80%
EXIT surveys completed	71	1057	864	+ 193 (22%)	942

7 Service Delivery

Key Points

- As a result of strong performance in March, the Trust delivered all of the Monitor performance standards across Quarter 4 and maintained a green governance rating.
- There is a risk of not achieving the new requirement to deliver the referral to treatment (RTT) waiting time targets at speciality level from April in a small number of specialities.

Referral to Treatment (RTT) Waiting Time Targets

7.1 The Monitor compliance framework includes the following two RTT targets:

- 95th percentile wait for admitted pathways (target 23 weeks)
- 95th percentile wait for non-admitted pathways (target 18.3 weeks)

7.2 In addition, the Department of Health continues to monitor the previous RTT targets (90% within 18 weeks for admitted pathways and 95% within 18 weeks for non-admitted pathways). A 95th percentile target of 28 weeks has also been added for incomplete (on-going) pathways.

7.3 Despite the risks highlighted previously, associated with the delivery of the RTT plan at specialty level, the Trust continued to achieve all five standards during March. Performance can be summarised as follows:

	Target	Standard	Achievement
MONITOR/DoH	95th percentile wait for admitted pathways	**23 weeks**	**22.5 weeks**
MONITOR/DoH	95th percentile wait for non-admitted pathways	**18.3 weeks**	**15.5 weeks**
DoH	Admitted – percentage of patients within 18 weeks	**90%**	**92.2%**
DoH	Non-admitted – percentage of patients within 18 weeks	**95%**	**96.7%**
DoH	95th percentile wait for on-going pathways	**28 weeks**	**18.5 weeks**

7.4 From 1 April there is a new national target that the RTT standards should be achieved across all specialities. A plan to achieve this target for admitted patients has been agreed as part of the contract with NHS Somerset, whereby fines will be imposed for underachievement at specialty level from April 2012, with the exception of orthopaedics and oral surgery, where delivery from July 2012 has been agreed. This plan is currently on track, although there remains a risk in relation to oral surgery due to a shortage of medical staff in this speciality.

7.5 Due to the complexity of some pathways and the effect which the small numbers of patients in some specialties can have on percentages, the major risk to the delivery of the new specialty-based targets is non-admitted pathways, and in particular oral surgery and plastic surgery.

7.6 The Trust continues to make good progress against the two new NHS Operating Framework standards for waiting times, which become live from 1 April 2012. These are:

- 92% of patients on incomplete pathways waiting less than 18 weeks
- No more than 1% of patients waiting longer than six weeks for a diagnostic test

7.7 Both of these standards were achieved during March.

7.8 Progress against the standards which will be in place from 1 April 2012 can be summarised as follows:

		Target	Nov - 11	Dec - 11	Jan - 12	Feb-12	Mar-12
MONITOR/DoH	Admitted RTT Performance	90%	91.9%	93.2%	90.8%	90.8%	92.2%
DoH	Admitted specialties not achieving 18 weeks	0	2	3	2	4	2
MONITOR/DoH	Non-admitted RTT Performance	95%	95.5%	95.2%	95.1%	95.3%	96.7%
DoH	Non-admitted specialties not achieving 18 weeks	0	4	6	7	7	5
MONITOR/DoH	Patients on incomplete pathway waiting 18 weeks or less	92%	80.6%	82.2%	93.3%	95.0%	94.6%
DoH	Proportion of patients waiting longer than six weeks for a diagnostic test	1%	0.3%	1.0%	1.3%	1.5%	0.1%

Cancer Waiting Times

7.9 Data for the cancer targets are sourced from the Somerset Cancer Register and continue to be fully validated one month in arrears. March data is, therefore, draft at this time and will be fully confirmed in mid-May. Performance is summarised in the first table on the next page.

7.10 Areas of note are as follows:

- The Trust achieved all of the Cancer standards during March 2012 and across Quarter 4, representing continued strong performance.
- The key risk within cancer services remains access to Oncology from the Beacon Centre. This continues to be managed at an operational level. The Trust is reviewing its service model for oncology provision and is in discussion with Taunton and Somerset NHS Foundation Trust regarding the direct employment of an oncologist to YDH.

Summary of Cancer Waiting Times Performance 2011/12

	Verified Open Exeter															DRAFT									
	Q1 Total			Q2 Total			Q3 Total			Jan-12			Feb-12			Mar-12			Q4 To Date			2011/12 Year to Date Total			Target
	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	Breaches	Referrals	Compliance	
2WW for all urgent cancers	90	1157	92.2%	64	1111	94.2%	80	1186	93.3%	24	363	93.4%	17	435	96.1%	30	466	93.6%	71	1264	94.4%	305	4718	93.5%	93%
2WW for Asymptomatic Breast Patients	8	127	93.7%	7	138	94.9%	4	133	97.0%	2	47	95.7%	1	53	98.1%	1	46	97.8%	4	146	97.3%	23	544	95.8%	93%
31 DAY TARGET 1st treatment	2	165	98.8%	2	158	98.7%	1	150	99.3%	1	73	98.6%	2	57	96.5%	1	66	98.5%	4	196	98.0%	9	669	98.7%	96%
31 DAY TARGET for subsequent treatments - DRUGS	0	30	100.0%	0	34	100.0%	0	44	100.0%	0	14	100.0%	0	12	100.0%	0	12	100.0%	0	38	100.0%	0	146	100.0%	98%
31 DAY TARGET for subsequent treatments - SURGERY	1	43	97.7%	2	53	96.2%	0	34	100.0%	0	17	100.0%	0	6	100.0%	0	16	100.0%	0	39	100.0%	3	169	98.2%	94%
62DAY TARGET for 2WW referrals	13	116	88.8%	8.5	98	91.3%	8	97.5	91.8%	2	48.5	95.9%	4	39	89.7%	4	40.5	90.1%	10	128	92.2%	39.5	439.5	91.0%	85%
62DAY TARGET for national screening	0.5	3	83.3%	0	2	100.0%	1	3	66.7%	0	0.5	100.0%	0	2.5	100.0%	0.5	5.5	90.9%	0.5	8.5	94.1%	2	16.5	87.9%	90%
62DAY TARGET for consultant upgrades	1.5	27	94.4%	0	31.5	100.0%	0.5	20	97.5%	0	15.5	100.0%	0	6	100.0%	0	14	100.0%	0	35.5	100.0%	2	114	98.2%	90%

Summary of Performance Against Emergency Department Quality Standards 2011/12

	Target	Standard	Q1 Total	Q2 Total	Q3 Total	Jan-12	Feb-12	Mar-12	Q4 Total	Total
MONITOR	Percentage of patients spending four hours or less in the Emergency Department	95%	95.02%	96.96%	96.65%	94.26 %	92.85 %	97.80 %	95.07%	95.92%
DoH	95th Percentile wait in the Emergency Department	≤ 4 hours	4:00 hrs	3:59 hrs	3:59 hrs	4:28 hrs	4:53 hrs	3:58 hrs	4:00 hrs	4:00 hrs
DoH	95th Percentile wait from arrival to initial assessment for ambulance patients	≤ 15 mins	37 mins	31 mins	25 mins	25 mins	30 mins	24 mins	27 mins	30 mins
DoH	Median waiting time from arrival to treatment	≤ 60 mins	1:13 hrs	1:06 hrs	50 mins	56 mins	1:08 hrs	58 mins	1:01 hrs	1:02 hrs
DoH	Un-panned re-attendance rate (within 7 days)	≤ 5%	3.5%	3.3%	3.5%	2.9%	3.7%	3.8%	3.5%	3.4%
DoH	Percentage of patients who left the department without being seen.	≤ 5%	2.4%	2.7%	1.6%	2.0%	1.8%	2.1%	2.0%	2.2%

Emergency Pathways

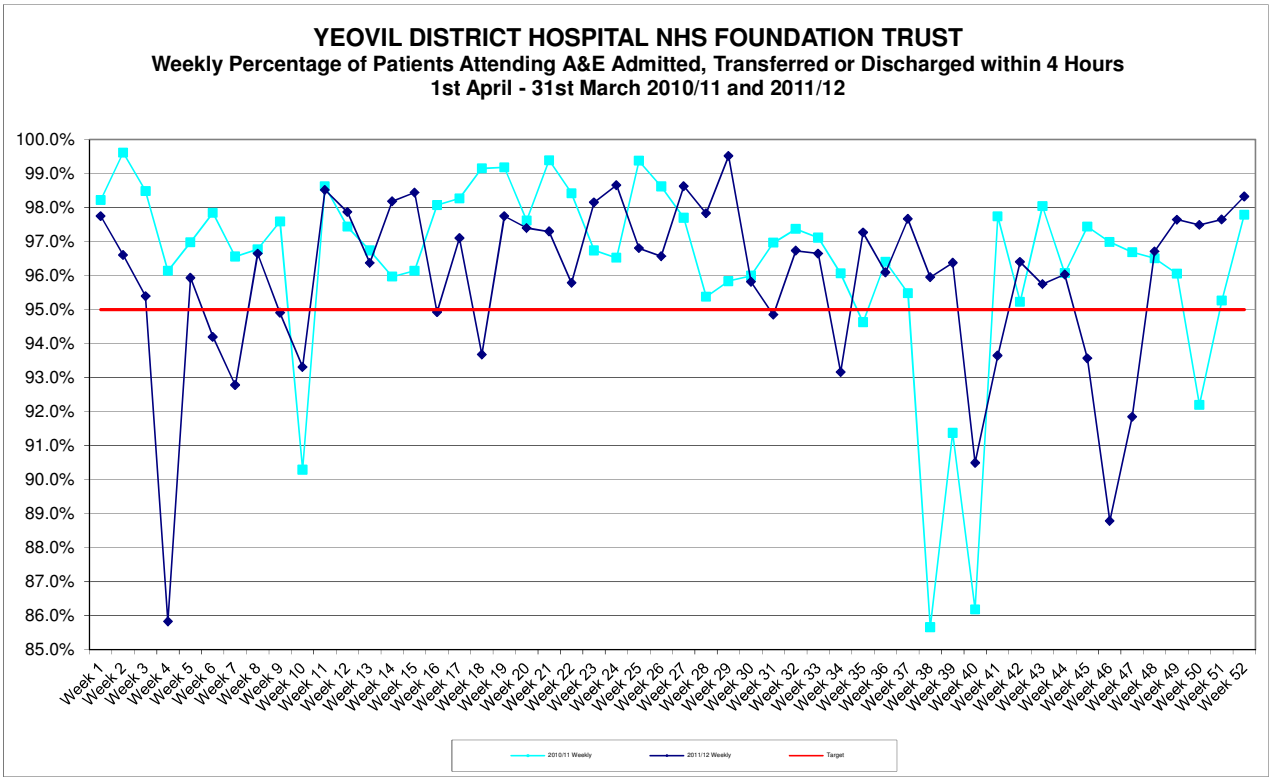
7.11 Performance against the six Emergency Department standards for the year to date is summarised in the second table on the previous page.

7.12 The Trust delivered strong performance against the 4-hour standard during March, with performance of 97.85%. This resulted in performance of 95.07% across Quarter 4 and 95.9% across the year as a whole.

7.13 Significant operational attention was paid to recovering the quarterly position following under-achievements in both January and February. This involved significant personal contributions from a number of individuals, which should be noted.

7.14 However, the aim moving forward is to focus effort on reducing the current variability through the delivery of the Emergency Care Pathway Transformational project.

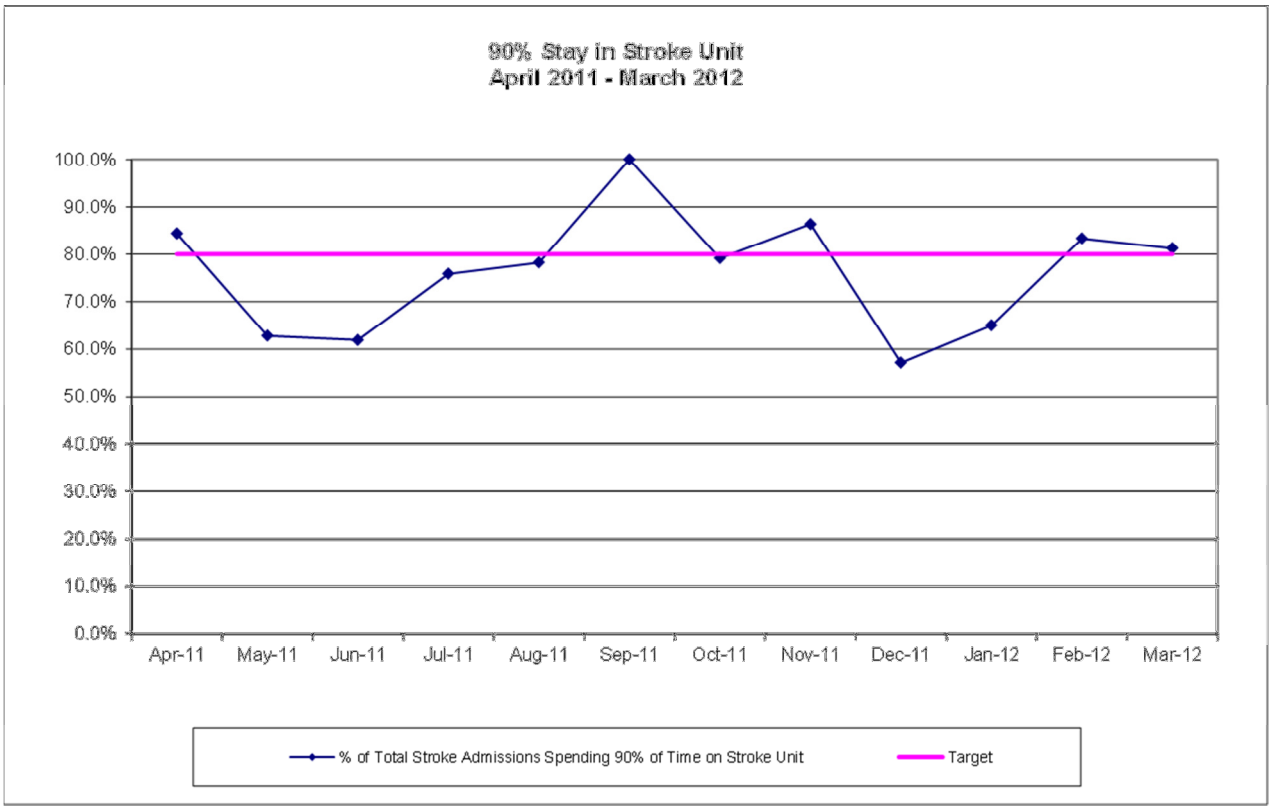
7.15 Weekly performance against the 4-hour standard across the year can be summarised as:



Stroke Care

Patients Spending 90% of their time on the Stroke Unit – (Target 80%)

7.16 A key indicator of the quality of stroke care delivered by the Trust is the percentage of patients spending 90% or more of their stay on the Stroke Unit.



7.17 The standard continued to be achieved during March with 81.3% of stroke patients admitted spending 90% or more of their time on the Stroke Unit.

7.18 This standard is now being delivered more consistently than in the past. However, there remains a degree of variation which needs to be reduced. In order to deliver a more sustained level of performance, the Trust is working with the NHS Institute for Innovation and Improvement to undertake a Stroke Pathway review. This work commenced on 4 April 2012 and is focussing on the internal pathway to streamline admission from the Emergency Department directly to the Acute Stoke Unit. An action plan has been developed to support this.

7.19 In addition, the Trust is working with NHS Somerset and Somerset Partnership NHS Foundation Trust to improve the process for transferring patients for on-going rehabilitation to the South Petherton Stroke Unit and in a review of the Early Supported discharge scheme.

TIA Clinic – High risk Transient Ischaemic Attacks (TIAs) receive treatment with 24 hours of referral (Target 60%)

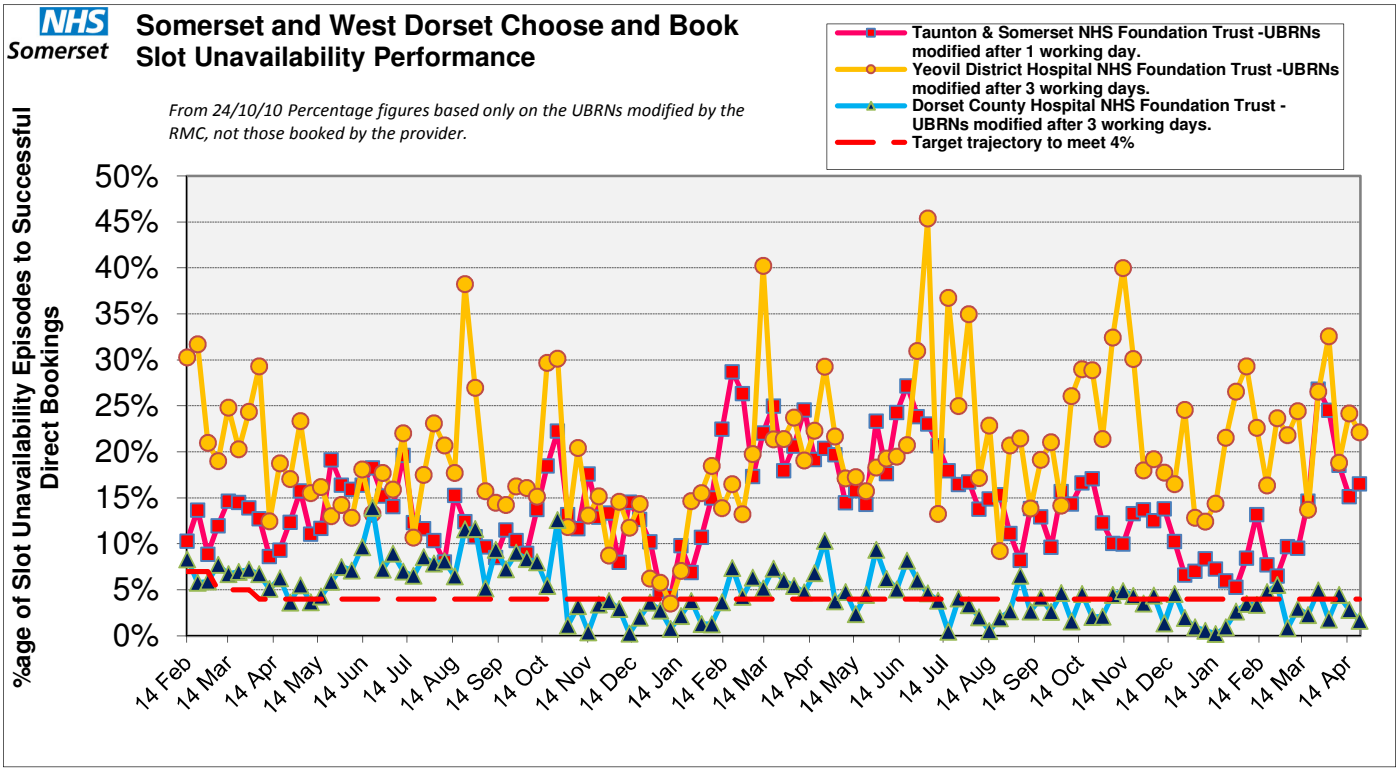
7.20 This standard was achieved during March, with 88.9% of patients being seen and treated within 24 hours.

Seen and treated within 24hrs?	**Q1**	**Q2**	**Q3**	**Jan-12**	**Feb-12**	**Mar-12**	**Q4**	**Total**
Yes	13	16	18	4	5	8	17	64
No	3	7	5	4	2	1	7	22
TOTAL HIGH RISK TIAs	**16**	**23**	**23**	**8**	**7**	**9**	**24**	**86**
% of High Risk TIAs Seen and Treated within 24hrs	**81.3%**	**69.6%**	**78.3%**	**50.0%**	**71.4%**	**88.9%**	**70.8%**	**74.4%**

Slot Availability

7.21 The Trust is an outlier for slot availability through the Choose and Book system for outpatient appointments. The most recent performance data indicates that for 22% of the patients who attempted to book an appointment at YDH there were no available slots to book into.

7.22 The graph below shows YDH's performance against that of other local trusts:



7.23 An action plan to address this issue has been agreed with Somerset PCT which focuses on ensuring that there is sufficient capacity available to meet patient demand, and also that as many services as possible are made available for direct booking through the Choose and Book system.

8 Human Resources (Annex 3)

Key points

- Seven out of eight HR indicators were positive this month (see appendix 3a).
- The pay underspend remained at £498k.

Staff in post against vacancies

8.1 The vacancy position increased in March from 59 to 64 and is green. Vacancies are fairly evenly spread across Divisions.

8.2 The position on medical vacancies has improved following overseas recruitment of additional middle grade doctors which is encouraging. The Clinical Director for Emergency Medicine has also developed a comprehensive workforce plan to reduce middle grade vacancies in that department which are to be implemented shortly.

Pay Budget Spend

8.3 The pay budget underspend increased again to £388k for the year. The reduction in agency spend compared to the same time the previous year was maintained. The spend over the whole year was £2million, compared to £2.8 million this time last year. Medical locum costs in particular were less than half the cost of the same period in 2010/11 - down from £1.5 million to £740k which is very positive.

8.4 The Trust is currently awaiting a national decision on whether to continue to run clinical excellence awards for medical staff before commencing this process locally.

8.5 Clinical on call arrangements for staff within the Agenda for Change pay bands are being reviewed with a view to standardisation in order to facilitate round the clock services in line with the aims of the clinical services strategy.

Sickness Absence Management

8.6 Sickness absence worsened during the year, with an end of year position of 3.6%, and an in month position for March of 4%, which was the highest in month position for many months. An investigation has taken place to assess the reasons for this and it appears that some departments could be more proactive in case-managing long term sickness in particular.

8.7 The cost of sickness absence per employee increased to £1,564, compared to £1,299 the previous year. The HR team are also working more closely with the departments with the highest areas of sickness to ensure that each area is applying the sickness management process effectively.

Mandatory Training

8.8 Mandatory training take up improved slightly to 67%. The Academy is considering grouping the 5 areas of mandatory training reported on the dashboard into a compact training session and/or some e-learning elements, to help improve compliance with mandatory training targets.

8.9 The Health and Safety reporting position has remained at 83% which is encouraging.

Appraisals

8.10 The appraisals rate in March was 72%, compared to 73% the previous month, and the full year position was also 73%. The appraisal policy and training have been reviewed and are due to be re-launched to help increase the quality and take up of appraisal.

Employee Relations

8.11 Local employee relations case management is green. There are a number of complicated cases across various professional groups.

8.12 The Nursery tender is underway with interviews of the two bidders taking place shortly.

Workforce planning

8.13 Workforce planning for staff aged 55 and over is green.

8.14 Job planning for consultant medical staff is still underway with 85% returned so far. A steering group of the Medical Director, Divisional Director and Director of Human Resources has been set up to drive these projects over the next year and beyond.

9 Finance Report (Annex 4)

Key Points

- The pre audited 2011/12 year end income and expenditure position was a surplus of £993,000 before extraordinary items. This represents a favourable variance against the annual budget of £718,000 as detailed in annex 4b.
- An impairment of £600,000 was incurred following revaluation of the Trust's estate including the refurbishment of the Macmillan unit. The impairment is classed as an exceptional item and therefore is excluded from the risk rating calculation.
- The cost improvement target of £4.8 million was achieved in 2011/12 but there was a shortfall in the recurring element of £518,000 which will be carried into 2012/13.
- The cash balance in the bank at the end of March was £6.1 million which was £1.5 million higher than planned due to timing on the capital programme.
- The final risk rating for 2011/12 was 3.2 which is rounded to 3. This was in line with plan.

Income and Expenditure

9.1 The income and expenditure position at the end of March 2012 was a surplus of £993,000 which represents a favourable variance of £718,000 year to date as detailed in annex 4b.

9.2 Private patient income was overachieved by £102,000 in 2011/12 and this was allocated to the cost improvement programme.

9.3 Pay expenditure was £84,000 favourable in month due to vacancies and the year-end position was a £388,000 underspend against all pay areas. Nursing costs were adverse in month by £26,000 which resulted in the year-end position being favourable by £2,000.

9.4 Activity related non-pay expenditure was £722,000 overspent at the end of the year and included within this was drugs costs of £233,000.

Divisional Risks

9.5 **Family Health and Clinical Support:** At the end of month 12 the division was £123,000 overspent against budget but fully achieved their cost improvement target with the exception of the private patient income element which was partially achieved.

9.6 **Surgery:** At the end of month 12 the division was £220,000 overspent against budget but their cost improvement target was achieved in 2011/12 with a shortfall against the non-recurring element of £109,000.

9.7 **Medicine:** At the end of month 12 the division was £360,000 overspent against budget but their cost improvement target was achieved in 2011/12 with a non-recurring element shortfall of £46,000.

Cost Improvement Plan

9.8 The cost improvement programme (CIP) was £4.8 million. This was achieved in year but £518,000 was not achieved recurrently. This has resulted in this balance being added to the plan for 2012/13.

Cash Flow

9.9 The Trust had £6.1 million in the bank at the end of March which was £1.5m above plan. The higher than planned cash balance is mainly attributable to the capital programme underspend as a number of projects commenced later than planned.

9.10 As at 31 March 2012 the Trust's cash investments were as follows:

Investment	Value at 31 March 12	Interest Rate at 31 March 12	Access Terms
Government Banking Service Accounts	£6,921,332	0.25%	Instant
Natwest Main Account	£36,680	0.00%	Instant
Natwest Special Interest	£126,774	0.30%	Instant
Natwest 90 day notice acc	£25	1.30%	Instant (90 day notice expired)
Bank of Scotland	£48,476	0.75%	Instant
Barclays	£2,289		
Less Cash in Transit	(£1,019,795)		
TOTAL	**£6,115,781**		

Capital

9.11 The capital budget for 2011/12 totalled £5.6 million. Expenditure on the 2011/12 capital programme as at 31 March 2012 was £4.2 million. This variance was because some expenditure commenced later than planned. Some of the year's underspend will be used to support the 2012/13 Capital Programme.

9.12 Completed projects in the year include the new combined heat and power plant, the pharmacy/pathology reconfiguration, the refurbishment of the Macmillan Unit, the new equipment library and the upgrade of the booking team's accommodation.

9.13 Projects still in progress include the new birthing pool, new entrance and ground floor clinics in the Women's Health and Maternity Unit, and the new CT scanner.

Financial Risk

9.14 The financial risk rating at the end of March 2012 was 3.2, as shown in the following table:

Metric	Value	Risk Rating	Weighting	Weighted Risk Rating
EBITDA achieved % of plan	115.6%	5	0.50	0.50
EBITDA margin	5.46%	3	0.25	0.80
Return on assets	5.44%	4	0.20	0.80
I&E surplus	0.55%	2	0.20	0.40
Liquidity days	22.56	3	0.25	0.75
Total				**3.2**

10 Recommendation

10.1 The Board of Directors is asked to DISCUSS the performance risks.

List of Annexes

1. Corporate Dashboard – March 2012
2. Quality:
    a. Infection prevention and control: key performance indicators
3. Human Resources:
    a. HR Performance Dashboard
    b. Average estimated cost of sickness
4. Finance:
    a. Executive Summary
    b. Income and expenditure under current contract
    c. Cost improvement summary dashboard
    d. Balance sheet
    e. Cashflow statement
    f. Capital expenditure