DIVISION OF MEDICINE FOR OLDER PEOPLE
Month 6 Performance Review - Exception Report

1) *Actions from Last Meeting*

Notes of meeting attached

"Performance Meeting 24-9 - DMOF

2) *Patient Experience*

- **Complaints**: ward and bed changes make it difficult to compare performance with last year; however the trend for increased complaints appears to have slowed. To date 24 formal and 10 informal complaints (17 & 8 in 08/08). The one ward that was previously highlighted as having received a high number of complaints has developed and implemented an action plan and in recent months has received no more complaints than any other acute ward
- **SUIs:** four currently outstanding: Mary Ward – DNAR confusion; Exton 7 Ward – death within 15 minutes of arrival; Anne Ward – death after fall; Guernsey Ward – death after confusion with medical gas for nebuliser
- **Staff dismissal:** member of staff has been found guilty in court of theft from patient
- **GWMH Inquests**: inquest into 10 deaths from 97/98 will take place in March 09 and is expected to run fro six weeks. This is likely to have a high media profile, locally and nationally. Mills and Reeve are supporting preparation, and acting as lead solicitor for all stake holder organisations. PHT Communications Team will be kept fully informed.

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3) *Performance Dashboard*

Draft Trust dashboard yet to be received. Divisional dashboard is to be presented to the Management and Governance Committee in October.

- **Admission target** achievement 6/12: 82% overall
- **Activity v SLA**: overachievement monies have been received for the acute wards, but there is concern that the rehabilitation wards will under perform because their tariff is OBDs, and thus efficiency of throughput has a negative effect
- **Outpatients**: national target maintained, Trust target very occasionally breached by a day or two through booking problems and loss of SpR time in clinics.

4) *Finance*

- **Month 6 budget position**: -£16,778
- **CIP**: targets met to date with £75,000 in reserve from Charles Ward closure to bridge any year end gaps
- **Palliative care PbR tariff:** change of from separate, to inclusion within acute tariff gives cause for concem. If the associated income is removed from the DMOP budget then it is unlikely that this service can be maintained, other than on a peripatetic basis.
- **Non acute tariff:** the non acute tariff is based on occupied bed days, which poses an income threat when beds are empty or closed. Increased throughput

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can bring increased income by enabling increased acute admissions, but this is only advantageous to if this increase is in DMOP admissions (the rehabilitation wards take admission from other Divisions, especially medicine and orthopaedics)

- **CIP requirements in 09/10**: when considering cost improvement programmes and potential savings plans, the Division is hamstrung in that the majority of costs relate to inpatient beds. There are no high cost specialist services to redesign/release cash. There are grave concerns that there are no large scale future savings to be made, other than closing another acute ward. Closing rehabilitation beds would result in a direct loss of income.

5) *Workforce*

- **Workforce plan**: slightly behind schedule with short delay in recruitment, linked with closure of Charles Ward. Recruitment to acute stroke is currently under way. Temporary staffing remains high at 7.9% (2.9% over target). However, this is directly related to the high level of vacancies not yet recruited to.
- **Consultant cover**: one consultant has resigned and two will be going on maternity leave, with all gaps occurring in February 2009. Plans are being developed and enacted with the aim of bridging these gaps at no, or minimal extra cost.
- **Nursing sickness** absence levels remain high (6.9%), based on HR data, although Firstcare data suggests a reduction. Regardless, sickness absence is still higher than other Divisions' and Brenda Gould will be leading a focused project with members of the management team to support ward sisters' in managing absence on their wards, and to more robustly performance manage this agenda.
- **Nursing skill mix** is 50% qualified/50% unqualified with a total staffing percentage of 62% professionally qualified staff, compared to the 70% SHA average. The Division has some concerns regarding the nursing skill mix and the acute wards will therefore, within current budget, move to 55% qualified/45% unqualified in June next year.

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6) *New Hospital*

- **Housekeeper role/cook chill**: the Division was unaware of the roll out of cook chill to south block wards in November 08, so consultation was not commenced with the current housekeepers in a timely fashion. The new housekeeper role will not cover the role currently undertaken so any money released from the current role will need to be reinvested in HCSWs to bridge the gap in patient care.
- **Nurse staffing**: the change in number and size of wards creates an opportunity to consolidate band 6 and 7 posts, and the modern matron posts – although any savings from the latter might be negated with service expansion during transition to business unit. The planned staffing model allows staffing ratio to be changed to 55%, and band 7s to be supernumerary two days per week: these changes will not be achieved if savings are expected from this reconfiguration.
- **All staff consultation papers have been developed and consultation meetings scheduled for November 2008.**
- **SMH Community Hospital Site**: DMOP will retain two rehabilitation wards and two day hospitals on this site. There is growing concern about ensuring adequate hotel, support services and medical out of hours cover. Guernsey Ward will remain in the stand alone building at the back of the site, which poses

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specific problems for some services, e.g. portering, so it is vital the Division is engaged in any service specification work with the PCT.

- **New Nursing Model for the Trust**: whilst supportive of the plan to redesign the nursing services within the trust, the Division is concerned to ensure that the complexity and geographical split of our services are fully considered and that Divisional managers are actively involved in any planning meetings, particularly those where potential savings are discussed. It is reassuring that no major changes will be made prior to the opening of the new hospital – the full engagement of all senior nurses will be essential for successful transfer of services.

7) ***Strategic Developments/Opportunities/Service Developments***

O8/09 Business Plans:

- Progressing well to date, no concerns and some areas planned for roll forward to 09/10

Planned Service Developments:

- **Acute medical care:** the size, role, function and management of the DMOP acute wards will need to be consolidated next year when all beds move onto the QAH site. This will offer opportunities for new ways of working, including swifter transfers from MAU.
- **Hyper Acute Stroke Unit**: stroke beds move to F3 next week. From this time direct admission will be possible and thrombolysis will commence opportunistically between 08:30 and 17:00 (time limitations due to CT and consultant availability). Acute TIA model cannot progress in F3 ward until 6 bedded bay released from medicine next year; in the meantime discussions are taking place about management of urgent TIAs in MAU.
- **Expansion of CSRT:** a business case is being developed to expand this home based service to the Petersfield, Gosport and Fareham areas. The local PCT have express interest in supporting this, but it is doubtful in the current climate if they would wish to invest beyond current tariff. The business case will explore the impact of inpatient versus home based services on related PbR tariffs, to estimate

Tenders:

- **Borden and Alton Community Geriatric Service:** this new service will soon go to tender - there are already links between this area and the service currently provided at LAU in Petersfield. This tender poses a conundrum for DMOP. If we place a successful bid we may then be required to refer acute admissions from this service to Winchester or Guildford – which would be complex. If we do not bid, or lose a bid we run the risk of the successful bid posing a threat to our current contract with LAU – with a potential associated loss of acute income for PHT. The current LAU service is provided at a loss and if we are to continue/expand this service we must either negotiate a contract that meet the DMOP costs in full, or agree how DMOP will be financially supported in running this service at a loss.

Intelligence:

- **New Treatment and Assessment Centres:** both PCTs are considering the future models for locality/intermediate care of older people, which has particular relevance to the future of Trevor Howell and Amulree Day Hospitals. Two workshops are planned, one with each PCT, to jointly explore service need. Both Day Hospitals provide much needed step up and step down care, but need

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to evolve to remain competitive in this market: there is a suggestion that future provision may go to tender. The Division will need corporate support to redesign the day hospital/assessments and treatment centre model.

- **Portsmouth City Provider Services:** there seems to be some discussion about the future of these services which might provide service development opportunities for DMOP. Conversely, the development of the SMH Community hospital site may offer an opportunity for these services to expand/develop and pose a threat to DMOP rehabilitation wards.
- **Review of Acquired Brain Injury Services in Hampshire:** Hants PCT is reviewing the provision of these services, which may offer business development opportunities for DMOP or other PHT services.

8) ***Any Other Business***

DMOP Management Team:

- **Structure**: the Division's continued success is testament to the creation of an efficient and effective management structure. The two operational managers are actively engaged in all aspects of management of their service portfolios, including patient flow and nurse staffing, whilst the risk manager has improved the rigour of risk identification and management.
- **DSN replacement**: whilst the future of this role may evolve within the new model of Business Units, it is crucial to the stability of the Division during that journey. Following external advert, the interviews for replacement take place on 4th November.
- **DGM replacement:** following much discussion the job description has been refocused and the title changed, to reflect the transition to Business Unit. External adverts will soon be placed, with the aim of securing an appointee with the skills, enthusiasm and energy to lead the Division on this journey. The new title for this post will be "Divisional Business Executive": the Divisional element will be dropped at a future time when sufficient other Business Units are in place.

9) ***Date of Next Meeting***

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Lesley Humphrey
DGM Medicine for Older People
22 October 2008

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