

#TEXTIanPiper

Operational Director 1.7.02

#CODENC

Role - lead responsibility for allocation and transfer of services of PCT. 2 day/week East Hants PCT - Director, general manager Elderly Medicine and Health. Recently 2002/3 SAFF process on behalf of PCT/PCG. Applying for PCT Executive. Lead for general manager. Overview meetings. CG Panel, Audit Panel, Finance and Performance Panel.

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#CODENC

How Top team works

#ENDCODE

#CODEA2

Delegation - how do you keep track.

Operational Team

#ENDCODE

#CODEB2

Delegation - how do you keep track.

Operational Team

#ENDCODE

#CODEB3

Financial year - away day - key issues. Mixture of operational and reconfiguration agenda.

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#CODED11

Personal Objectives.

Performance review 2000/01 and key objective 2002/03.

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#CODEB4

Quarterly divisional process. Performance Review Process agreed upon common template.

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#CODEB4

Weekly meeting general manager. 6 GM's. 1 - 1 1/2 hours.

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#CODEA2

Weekly meeting general manager. 6 GM's. 1 - 1 1/2 hours.

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#CODEB4

Monthly operational management group - policy dev key op issues. Ian - Chairs.

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#CODEB1

Chair risk management group.

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Where would hot issues be translated into actions?

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#CODEB3

Ring Ian or Max, group meeting, fortnightly ED meetings, review and comms briefing, forms/key documentation.

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Is it clear how to react to a critical incident from board to floor level?

Yes - no problem in speaking out about filling in a critical incident form. This format has emerged since 1999 CARE KEY. Current risk event system.

Critical incident review policy.

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\*Communications - how do you know policy is working?

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#CODEA1

Visit wards GWMH 4 trips since March. Elderly Med - 3 x since March.

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Good relations with staff reps. Comms with other director.

Regular programme of clinical teams coming to present to the board.

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#CODEB4

\*Involvement of clinical and front line staff in perf manage?

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#CODEK2

Team have own clinical governance service plan - with lead consultants ie GWMH - F + G Team Management.

Consultant engaged on CG Team (nurses involved CG nursing) -> Clinicians attend formal reviews -> Clinicians present papers.

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#CODEB4

Divisional reviews clinicians are attending on specific issues but minutes are sent to those absent.

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#CODEB1

Accountability. Lead Consultants - not line managed by F.C. but internally managed by each division. - They work alongside divisions.

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#CODEB2

Something may have been delegated by accountability would not change.

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#CODEB3

Consideration given to using the model in place now for elderly medicine to the new PCT? Beds geographically retained local focus - but maintaining a strong linkage d/w two PCT.

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#CODENC

What mechanisms will stop acute dumping beds.

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#CODEA3

It will be prevented by NSF, PAMS, F + G and E HAMP PCT relate to Hampshire as far as social services are concerned.

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#CODEA3

Operational issues with new model in PCT

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#CODEB3

- planning of elderly services needs to be strategic.

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#CODEG4

Elderly services - HA/ Trust/ Acute. Communication in the past.

#ENDCODE

#CODEG5

Elderly services - HA/ Trust/ Acute. Communication in the past.

#ENDCODE

#CODEG6

Elderly services - HA/ Trust/ Acute. Communication in the past.

#ENDCODE

#CODEB3

M.D Martin Severes 1990 - developed stroke services.

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#CODEB3

Last 3 - 4 years Int Care, separation of ward functions? The driver was Nicky Pendleton - general manager for elderly medicine.

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#CODENC

CES -> enabling elderly people to sustain independency preventing inappropriate admission and facilitating discharge. Audited? Mar - April 2001 evaluation of Int Care Schemes.

CES works alongside step down beds/ int/care.

FD1998 - Financial health and stability 97 ->.

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#CODENC

Fareham and Gosport. Marginally tighter. Effectively managed demo in review process.

Finances has been under control. Recurring investment - Int Care 7 -800,000 allowed additional staffing and richer skill mix.

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#CODEB3

No successful CREZ programmes. Very pragmatic approach to CREZ by keeping health level of reserve.

le. Recurring 1/2 - 3/4 million on turnover of 100 million. le CPR training received 80,000 recurring funds.

#ENDCODE

#CODEG7

No successful CREZ programmes. Very pragmatic approach to CREZ by keeping health level of reserve.

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#CODEB4

1998 - Incidents

Made aware through divisional review process as complaints.

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#CODEJ2

1998 - Incidents

Made aware through divisional review process as complaints.

#ENDCODE

#CODEB4

Information translated to board on quarterly meetings.

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#CODENC

Qualitative aspect -> Awareness of feelings involved in complaints?

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#CODEJ1

Awareness built up as time progressed of the three complaints together.

#ENDCODE

#CODEJ3

Awareness built up as time progressed of the three complaints together.

#ENDCODE

#CODEJ1

Dealing with complaints -> very quick changes in processes and systems.

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#CODEJ1

Timing of complaints should have been considered in hindsight which may have triggered changes more sooner.

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#CODENC

Review and monitoring changes.

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#CODEJ3

Very good at ID issues - but weak point would have been closing the loop but this was resolved with clinical governance.

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#CODEJ4

Very good at ID issues - but weak point would have been closing the loop but this was resolved with clinical governance.

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#CODENC

1998- Reviews - 3 or 4.

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#CODENC

How do you know about good practice / bad practice?

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#CODEC1

Informal and formal relationships. Staff opinion surveys.

Points.

1 Clear set of values. Value used to structure for framework and business views - 4 key values.

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#CODEA1

2 Partnership with voluntary organisations, CHC, as well as internal. In external meetings people speak highly.

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#CODEC1

3 Distinct audit and staff reports. Show values and good practice.

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#CODEB4

4 Perf deliver clinical governance and activity targets and financial targets.

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#CODENC

5 Open - no blame culture works and clear about accountability and empowerment.

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