Alan Carpenter

GOSPORT INVESTIGATION REPORT
KEY POINTS

A. Trust Strategic

A1 Leadership

The trust has strong leadership focussed on users and staff. The latter comes through strongly. There is a strong, competent corporate team. The Chief Executive is prominent and well regarded.

A2 Accountabilities

There appears to be a balance between a strong corporate and divisional approaches. The divisional model seems to work. There is a sound performance management framework in the Trust. There appear to be effective core processes. Accountabilities seem to be clear.

A3 Direction and planning

There are robust processes in place, including financial planning. There was no real pressure on older people's services over the last three to four years, because the Trust took a corporate view on CRES and funded it from reserves. I have a worry about the fragmenting effect on this, and services, from the move to PCTs. The move has been well co-ordinated, bit there are inherent risks- with different components of the services going to different PCTs.

A4 Health economy partnerships

PHCT are regarded as a good strong player in the local economy. There is close working with the HA. I'm unclear about working with the acute Trust.

A5 Patient and public partners

The Trust has a strong focus here. It's more developed in mental health and disability services and less so in older people's. However, there are good examples of practice around and a Trust framework.

B. Service strategic

B1. Leadership

Strong service leadership exists now- but it's unclear if it did in 1998. The people and mechanisms appear reasonable and nothing obviously out of line. There also seem to be clear implementation mechanisms now, and reviews of these through the divisional review structure.

B2 Accountabilities

A crucial feature here is the parallel working of E.T. (professional issues) and F.C. (managerial issues). It appears to be working now. In 1998 there wasn't that degree of practice focus, or synthesised working. In addition, then there were clearly some serious problems with the Dryad Sister.

B3 Direction and planning

Already covered a bit. This all seemed quite reasonable, with strong corporate and HA leads.

B4 Service performance management

It is unclear how good these arrangements are below divisional level. There are plenty of meetings (of managers) sub division and lots of opportunity to cover this area, but I'm unclear if these are picked up systematically. Nothing unusual here- except they had this big issue, and knew about the dryad sister issue.

C. Other general observations

- Good vertical processes in Trust with strong services focus through clinical governance framework and review meetings

- Unclear roles of Dryad and Daedelus wards

- Limited multi-professional working on Dryad and Daedelus Wards (ie in assessment or goal setting)

- Question marks about medical cover and support. By day the staff grade doctor seems isolated. At night, the OOH cover brings some clinical governance and quality issues. These are normal arrangements elsewhere.

- Considering the above point, the supervision of medical staff on the wards needs to be strengthened

- There were extremely unhealthy staff dynamics on Dryad Ward back before, and during, 1998- especially with the Dr B and ward sister axis.

- Question about how the trust learns(ed) about really important mistakes

D. Key issues from a management point of view (not covered previously)

The nature of the OOH contract with the local GPs, including the use of Healthcall, its monitoring, its quality and so on.

The return of Dryad's ward sister! *

Sense that a strong personnel function means that their procedures dominate management imperatives sometimes, viz *.

Good complaints procedure

Able managers at the moment

Alan Carpenter
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