Agenda Item: 7
Enclosure No: TB2015/024

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS
NHS Trust

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**PUBLIC BOARD PAPER**
**25th March 2015**

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| **Title** | Learning from the Speaking Out Independent Investigation into Savile's association with Stoke Mandeville Hospital |
| **Responsible Director** | Chief Executive Officer |
| **Purpose of the paper** | On the 25th February 2015 the Speaking Out Independent Investigation into Savile's association with Stoke Mandeville Hospital was published.<br><br>On the same day the 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile' report by Kate Lampard and Ed Marsden was also published.<br><br>The purpose of this paper is to provide the Board with the opportunity to accept the recommendations within both the Speaking Out Independent Investigation report and Kate Lampard's report into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'.<br><br>The report also provides assurance to the Board with regard to progress against actions arising from recommendations within the Speaking Out Independent Investigation report. |
| **Action / decision required (e.g., approve, support, endorse)** | • Decision to accept the recommendations within the Speaking Out Independent Investigation report<br>• Decision to accept the recommendations relevant to NHS Trusts within Kate Lampard's report into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'.<br>• Endorse the actions taken in response to the recommendations within the Speaking Out Independent Investigation report |

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**Links to BHT Business and Risks**

| **Implications and issues to which the paper relates (please mark in bold)** | | | | | |
|---|---|---|---|---|---|
| **Patient Quality** | Financial Performance | Operational Performance | Strategy | FT Application | New or elevated risk |
| Legal | Regulatory/ Compliance | **Public Engagement /Reputation** | Equality & Diversity | Partnership Working | Other |

| | |
|---|---|
| **Annual Objective** | Safe and compassionate care every time |
| **Links to BHT Board Assurance Framework/Corporate Risk Register** | |
| BAF/Corporate Risk Register Reference | BAF 2b |
| Risk Description | Risk that public perception of the organisation's safeguarding processes may be affected when the report is published. |
| CQC Reg. Ref. | Outcome 7, Safeguarding |
| **Author of Paper** | |
| Anne Eden | |
| **Presenter of Paper** | |
| **Anne Ede** | |
| **Other committees / groups where this paper / item has been considered** | |
| **n/a** | |
| **Date of Paper** | |
| **13th March 2015** | |

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**Learning from the Speaking Out Independent Investigation into Savile's association with Stoke Mandeville Hospital**

## 1. PURPOSE

The purpose of this paper is to provide the Board with the opportunity to consider the recommendations within both the Speaking Out Independent Investigation report and Kate Lampard's overarching report for the whole NHS into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'.

The report also provides assurance to the Board with regard to progress against actions arising from recommendations within the Speaking Out Independent Investigation report.

## 2. BACKGROUND

In October 2012 allegations relating to the late Jimmy Savile started to emerge through the media. In response to this the Trust immediately initiated an independent investigation into Savile's association with Stoke Mandeville Hospital. This investigation along with a number of other NHS investigations, was carried out under the oversight of Kate Lampard who was appointed by the Secretary of State for Health into this oversight role.

The investigation was carried out by Dr Androulla Johnstone from the Health and Social Care Advisory Service. Dr Johnstone and her team carried out a comprehensive document review and interviewed over 250 witnesses. Among these witnesses were a number of victims. All victims and witnesses were offered support throughout the process.

After the main investigation ceased gathering evidence a small number of people came forward with new accounts. These were investigated by independent investigators from Oxford Health and published as a Legacy report, and was one of 15 legacy investigations conducted nationwide.

The Speaking Out Independent Investigation report was published on the 25th February 2015 at a national launch. The Legacy report was also published on the same day.

## 3. FINDINGS AND RECOMMENDATIONS FROM THE SPEAKING OUT INVESTIGATION

All reports are available at http://www.speakingoutinvestigation.com/reports.htm .

The Legacy report is also available as follows:
http://www.speakingoutinvestigation.com/Downloads/Speaking%20out%20investigation/2903580_Legacy%20Report%20Accessible%20v2.pdf

This section will summarise the key findings from the report, list the recommendations and set out the actions which have been taken in response to these recommendations.

**SUMMARY OF FINDINGS**

**1968 – 1992**

The investigation found that between 1968 and 1992 Savile sexually abused 60 individuals connected with Stoke Mandeville Hospital. These victims ranged in age from 8 to 40 years. The victims were patients, staff, visitors, volunteers and charity fundraisers. The sexual abused ranged from inappropriate touching to rape. Savile was an opportunistic predator who could also on occasions showed a high degree of premeditation when planning attacks on his victims.

The report concludes that although a small number of information verbal reports and one formal complaint (which was subsequently dropped by the complainant's father due to her serious ill health) were made, none of these were escalated to senior management. Consequently no intelligence about Savile's behaviour was gathered over the years and no action was taken.

In 1969 Savile came to Stoke Mandeville Hospital as a voluntary porter. He was appointed with no checks, monitoring or supervision in place. He was given accommodation on the hospital site and at that time had 24-hour seven day a week access to all parts of the hospital building complex. From an early stage his disruptive behaviour and constant sexual innuendo caused annoyance and distress to the junior staff within the hospital. However his behaviour was explained away as being part of his eccentric celebrity persona. Savile was feted by senior managers as an important asset to the organisation where he was quickly established as an integral part of hospital life. It would appear that at no stage were senior managers made aware of either his sexual offending or his unsatisfactory portering performance and poor moral behaviour.

From 1980 Savile's relationship with Stoke Mandeville Hospital underwent a significant change when he was appointed by Government Ministers and the Department of Health and Social Security (DHSS) to fundraise for, and lead the commissioning process of, the new National Spinal Injuries Centre (NSIC). This placed Savile in a position of authority. He had no previous experience of managing a project of this kind and no checks or balances were put in place. Whilst Savile ensured the NSIC was rebuilt on time and within budget no formal planning processes were deployed and from the outset it was apparent that the NSIC was not financially viable in the long-term. Savile became an ever increasingly difficult and trouble-making influence at the hospital. There were two major consequences. First: there was a dependence upon Savile's charitable funds for the next twenty years which ensured his continued position of power and influence at the hospital which was often detrimental to service management. Second: Savile was able to access a new cohort of victims for his sexual abuse in the guise of young charity fundraisers to the hospital.

Victims felt unable at the time to report Savile's behaviour. This was because they feared they would not be believed as Savile was seen as being a powerful and influential figure.

**1991 – 1994**

The Stoke Mandeville Hospital NHS Trust Board elect (1991) and formally appointed NHS Trust Board (1994) tackled Savile 'head on' from 1991 and, whilst it was to take several years, were able to control Savile and diminish his authority. The placing of statutory powers at local service provider level allowed the NHS Trust to address what had become an unworkable situation.

At the same time, the Hospital introduced more restrictions and stringent processes, thanks in part to clear and unambiguous national guidance on procedures for complaints, whistleblowing, security, staff checks and volunteering. These factors combined to create a climate that was no longer conducive to a continuation of either Savile's managerial authority or his opportunistic sexual abuse.

**2015 Current situation**

The current Buckinghamshire Healthcare NHS Trust has undergone a stringent process of review and investigation in relation to safeguarding and governance. Today Stoke Mandeville is a very different place. The Investigation says that now: "The Trust has a safeguarding team of experienced and qualified staff members who are fully aware of the importance of safeguarding" and it "has not found any safeguarding related situation where either children or vulnerable adults have been at risk."

**RECOMMENDATIONS**

**Recommendation One – Disclosure and Barring**

The Trust should:

Ensure that the register of all voluntary services within the Trust is complete, accurate and able to confirm:

- how many volunteers are deployed across the organisation and in what capacity;
- how many volunteers are currently subject to a DBS (Disclosure and Barring Service) check;
- the current risks in relation to unsupervised contact between volunteers (in all occupations) and children and vulnerable adults;
- whether there are voluntary service roles that are currently not put forward for a DBS check but should be in the future;
- the supervisory arrangements that currently exist for volunteer roles;
- whether any additional supervisory arrangements need to be in place for volunteers who may have unsupervised access to patients and the general public and who do not meet the DBS criteria.

The Trust should then agree the frequency of ongoing audit checking of this volunteer services register.

**Recommendation Two – Celebrity Visitors**

The Trust should:

by the time of publication, have amended and made available its current volunteer and visiting policy to include procedures to take into account all celebrities and VIPs (including politicians) who may visit the organisation. It should become a tenet of basic Trust policy that every individual, regardless of their status, will be treated in the same rigorous manner as all other visitors to the Trust; set out clear celebrity and fundraiser guidance regarding access, conduct and supervision which will be given to each visitor;

ensure that a senior officer of the Trust will be nominated as being both responsible and accountable for each celebrity or fundraising visitor; audit this policy six months after the publication of this report, to review the application of the new procedures for effectiveness and safety.

The Trust should establish the ongoing frequency of future audits of the effectiveness and consistent application of the volunteer and visiting policy.

**Recommendation Three – Accident and Emergency**

The Trust should:

Ensure that an audit in Accident and Emergency is conducted which:

- tests the consistency of application of current safeguarding policies and procedures regarding children and vulnerable adults in all accident and emergency contexts;
- confirms and provides disaggregated accident and emergency safeguarding data;
- confirms and provides training and supervision records for accident and emergency staff;
- confirms and provides detailed information about all safeguarding concerns raised regarding both children and vulnerable adults over the past 18 months confirms that adequate information exists to track each individual case to ensure that all correct processes were followed (for example, reporting to the Local Authority Designated Officer);
- confirms and provides detailed information about staffing levels;
- confirms and provides detailed information about the safeguarding complaints raised by patients and the subsequent actions taken to ensure resolution and ongoing service improvement.
- The ongoing frequency of the accident and emergency services audit will be agreed by the Trust in conjunction with its commissioners

**Recommendation Four – Raising Concerns**

The Trust should:

Conduct a series of events in order to understand in detail any barriers that may prevent either patients or staff reporting complaints, concerns and incidents. This will be achieved by:

- conducting both a staff and patient survey to establish levels of confidence in reporting systems and to provide feedback regarding the Trust culture (both barriers to openness and positive factors);
- holding regular focus events within local patient advocacy groups;
- holding regular focus events with chaplaincy and occupational health (as these are the mechanisms through which staff concerns are often routed when whistleblowing processes fail);
- holding regular focus events with staff, to include junior doctors particularly at the end of their training.

**Recommendation Five – Complaints**

The Trust should:

Conduct an audit of its current complaints processes to ensure that:

- current Trust policies and procedures have been amended to take into account the expectations and recommendations set out in the above review;
- Trust induction and staff training events are reviewed to take into account the expectations and recommendations set out in the review;
- patient and visitor information is amended to take into account the expectations and recommendations set out in the review;
- all relevant policy documents and training materials provide explicit detail regarding how to support and protect vulnerable adults when making complaints about NHS services;
- opportunities to learn and subsequent action taken are clearly visible to all in the Trust and extensively presented to encourage an improving culture of openness.

**Recommendation Six – Support for victims of abuse**

During the course of the Investigation, work has been undertaken to ensure the safety and support of the victims of Savile's sexual abuse. Buckinghamshire Healthcare NHS Trust, the Local Authority, Buckinghamshire Clinical Commissioning Group and Oxford Health NHS Foundation Trust should review local circumstances to ensure that support can be offered to other victims of sexual abuse in the future.

**Recommendation Seven – Document Archiving**

The Trust should:

Conduct a review of its current document archiving and destruction processes to ensure that:

- no Trust documents are stored in 'unofficial' locations such as loft spaces;
- consideration is taken as to whether some documents should be scanned and stored electronically when hard copies are destroyed (such as clinical records, outdated policies and procedures etc.);
- a formal catalogue is created detailing exactly where documentation is stored.

**Recommendation Eight – Embedding the actions**

The Trust should:

- arrange a focus event with key local stakeholders (for example, staff groups, patient groups and commissioning bodies) to ensure there is a wide understanding of the findings in the report, the recommendations and the actions that the Trust is undertaking;

- ensure that, in conjunction with stakeholders, enduring and fit-for- purpose systems are put into place to guarantee that the lessons for learning from this report are understood and lead to service improvement.

**RESPONSE TO THE RECOMMENDATIONS**

It is recommended that the Board accepts all the recommendations as set out in the report. The following actions have already been taken:

- We have put in place a comprehensive register of volunteers and all volunteers have undergone DBS checks whatever their volunteering role. All existing volunteers and new volunteers are recorded on the register and in addition to new entries the register is also updated on an annual basis to ensure information about volunteers is kept up-to-date and to provide assurance that volunteers are receiving an appropriate level of supervision

- We have put in place a new approved visitor policy. All visitors are subject to supervision regardless of their celebrity status.

- We have strengthened training and awareness of safeguarding issues in the Accident and Emergency Department. In recognition of the pivotal role that A&E staff often have in identifying safeguarding issues we continue to make this a key area of focus and development.

- We have strengthened our Whistleblowing and process for raising concerns and displayed a poster in all areas to remind staff how to use the process. There are a number of ongoing initiatives to ensure that this continues to be an area of focus such as externally facilitated junior doctor feedback sessions, the Speak Out Safely campaign, and the launch of a 'hotline' where staff can raise concerns.

- We have been working with our buddy organisation, Salford Royal NHS Foundation Trust on strengthening our complaints processes. Our complaints policy is in the process of being revised to ensure that recommendations from the report are incorporated and acted upon.

- We have developed and implemented a successful programme of support for victims of sexual abuse in partnership with Oxford Health NHS Foundation Trust.

- We have a system of Document Controllers across the organisation that are responsible for the management and archiving of key documents. This enables us to have a catalogue for where information is held in the organisation.

- We have put considerable energy and effort into engaging with staff and stakeholders around our Quality Improvement Strategy. One important element within this strategy is the continued building of an open, learning culture across the organisation.

## 4. NEXT STEPS /WAY FORWARD

It is important for the organisation to reflect on the learning from the report and to provide assurance to the Board around progress against the recommendations. The Trust Management Committee will take this forward under the leadership of the Medical Director.

The organisation also needs time to consider the implications of Kate Lampard's report into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'. There is some overlap with the recommendations from the Speaking Out Investigation, but also some more general points. Again the Board is recommended to accept the recommendations relevant to NHS Trusts. All Chief Executives of NHS Trusts have received a letter from David Flory, CEO of the NHS Trust Development Authority asking them to prepare an action plan in response to these recommendations by the end of May 2015.

The Trust Management Committee will have responsibility for reviewing our compliance against the recommendations and putting in place an action plan to deliver any necessary changes under the leadership of the Medical Director.

## 5. CONCLUSION

Savile's victims have shown great courage in coming forward with their accounts as part of the investigation process. Although the events took place between 25 and 50 years ago it is important that the improved processes that have been put in place since that time continue to effectively reduce the risk of this ever happening again.

The Trust Chair has issued an unreserved apology to Savile's victims that such events could take place in an NHS organisation.

## 6. RECOMMENDATION

It is recommended that the Board:

- Decision to accept the recommendations within the Speaking Out Independent Investigation report
- Decision to accept the recommendations relevant to NHS Trusts within Kate Lampard's report into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'.
- Endorse the actions taken in response to the recommendations within the Speaking Out Independent Investigation report