SUMMARY REPORT	South Tees Hospitals NHS NHS Foundation Trust
Board of Directors	Date of meeting 26 May 2015

Subject	Report on the themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile
Prepared by	Ruth Holt, Caroline Parnell, Andrew Thacker, Rachael Metcalf, Emma Rushmer, Helen Smithies
Approved by	Ruth Holt
Presented by	Ruth Holt, Director of Nursing and DIPC
Name of meeting considered/approved by	Quality Assurance Committee

Purpose		
To update the Board on actions taken following the publication of the report	Decision	
	Approval	
	Information	●
	Assurance	

Executive Summary

The report lists the Trust's current position and actions to be taken in response to the learning from the enquiry. The action plan was agreed at the Quality Assurance Committee on 13 May 2015 and will be submitted to Monitor.

Next Steps

1. The report will be submitted to Monitor in advance of the 15 June deadline.
2. A further report updating on actions taken will be presented to the Quality Assurance Committee in November 2015.

Supports Trust Strategy Map in the following areas

quality & patient safety		business sustainability		operational excellence		organisational capability	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety	●	enhanced services				strong partnerships & engagement	

If a key risk(s) has been identified, please describe below

Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

The Trust's Quality Assurance Committee received a report at its meeting on 10 September 2014, which formed a response to "The Report of the Investigation into matters relating to Jimmy Savile at Leeds". This was one of 28 reports into abuse by Savile in NHS organisations.

'The themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile' (Kate Lampard 2015) addresses the following themes:

- security and access arrangements, including celebrity and VIP access
- the role and management of volunteers
- safeguarding
- raising complaints and concerns (by staff and patients)
- fundraising and charity governance; and
- observance of due process and good governance.

On the day of publication in June 2014 the Secretary of State made a statement to the House of Commons. Among other remarks about the outcomes of the investigations, he said:

> *"There are some painfully obvious lessons for the system as a whole. First, we must never give people the kind of access that Savile enjoyed to wards and patients without proper checks, whoever that person may be. Secondly, if people are abusive, staff should feel supported to challenge them, whoever that person may be, and take swift action. Thirdly, where patients report abuse, they need to be listened to, whatever their age, whatever their condition, and there needs to be proper investigation of what they report. It is deeply shocking that so few people felt that they could speak up and even more shocking that no one listened to those who did speak up. That is now changing in the NHS, but we have a long way to go.*
>
> *In ensuring appropriate measures, we must not hinder the extraordinary contribution of thousands of volunteers and fundraisers working in the NHS every day. They are the opposite of Savile and we need to ensure that their remarkable contribution is sustained."*

Recommendations are made for NHS Trusts, Monitor, The Trust Development Authority and Care Quality Commission. These have been reviewed by senior staff in the Trust and issues identified and actions determined to address these.

There are no areas of serious concern however a number of actions need to be taken (see Annex A attached).

RECOMMENDATIONS:

1. The report will be submitted to Monitor in advance of the 15 June deadline.
2. A further report updating on actions taken will be presented to the Quality Assurance Committee in November 2015.

RUTH HOLT
DIRECTOR OF NURSING AND DIPC

MAY 2015