

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

Independent report for the Secretary of State for Health

February 2015

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Ed Marsden

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1. Foreword

1.1 In October 2012 the Secretary of State for Health asked me to provide independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the Department, and allegations that Savile committed sexual abuses on the hospitals' premises.

1.2 Following my appointment to that oversight role and in the wake of increasing concern about the nature and enormity of Savile's activities, the Secretary of State also asked me to identify the themes that would emerge from the investigations and to look at NHS-wide procedures in light of the investigations' findings and recommendations. Subsequently, I was also asked to include in my considerations the findings of internal investigations into further allegations of abuse by Savile at various other NHS hospital sites.

1.3 I have been supported by Ed Marsden, managing partner of Verita, a firm experienced in handling investigations in public sector and other organisations. This report describes our joint work and sets out our joint findings and recommendations. Our biographies can be found at appendix A. We are very grateful to Chloe Taylor, administrative assistant at Verita, for her help in organising our work.

1.4 We summarise in this report the findings of the reports of the NHS Savile investigations. We describe and consider the themes and issues that emerge from those findings and the further evidence we gathered. We identify lessons to be drawn by the NHS as a whole from the Savile affair and we make relevant recommendations.

1.5 Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissitic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today. These matters are considered in this report.

1.6 In light of other recent sex abuse scandals and allegations, the lessons learnt from the Savile case must form part of a wider public conversation about how all professionals and public bodies identify abuse and act to tackle it.

Kate Lampard

February 2015

2. Introduction

2.1 An ITV Exposure programme broadcast in October 2012 involved allegations made by five women that Savile had sexually abused them. They said the abuse had taken place between 1968 and 1974 when they were teenagers. After the broadcast, the Metropolitan Police Service (MPS) took responsibility for assessing the claims it contained and invited others who had experienced abuse by Savile to report it to them. The MPS operation was given the name "Yewtree". Many hundreds of people have since made allegations and given evidence to Operation Yewtree about sexual abuse committed by Savile and others.

2.2 After the Exposure programme and the setting up of Operation Yewtree, reports surfaced of Savile having committed sexual abuses at the three NHS hospitals with which he had had long-term associations, namely Stoke Mandeville, Leeds General Infirmary and Broadmoor. In response, three major investigations were set up by the NHS trusts now responsible for the hospital sites in question (Buckinghamshire Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust and West London Mental Health NHS Trust). The investigation relating to Broadmoor Hospital was jointly commissioned with the Department of Health as that department (previously the Department of Health and Social Security) had had direct management responsibility for Broadmoor at the time that Savile first became involved with the hospital and during a significant part of the time that he was associated with it. The terms of reference for the Stoke Mandeville investigation were in due course widened to encompass the Department of Health's part in Savile's relationship with that hospital too.

2.3 The Secretary of State for Health asked me in a letter dated 29 October 2012 (at page 124 in appendix B to this report) to provide independent oversight of the investigations being undertaken at Leeds General Infirmary, Stoke Mandeville and Broadmoor Hospitals and the Department of Health.

2.4 Once the scale of Savile's alleged activities at the three hospitals had become clearer and when concern about those activities was increasing, the Secretary of State for Health wrote to me again on 12 November 2012 (page 125 in appendix B to this report). His letter says:

"It is inevitable that as you sample and assure yourself that the processes the organisations have followed are robust, you will identify themes. I would

therefore like to ask you to look too at NHS wide procedures in the light of the findings and recommendations of the reviews you are overseeing once they have been completed, seeking expert advice as necessary, and see whether they need to be tightened. If so, I would very much like you to advise me how any relevant guidelines or procedures need to be changed.

I am particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role.”

2.5 I met the Secretary of State for Health in late November 2012 to discuss the work he had asked me to do in relation to Savile’s associations with NHS organisations.

2.6 The MPS informed the Department of Health at the beginning of December 2012 about allegations that Savile had committed a single or possibly two sexual offences at other NHS hospitals besides Stoke Mandeville, Leeds General Infirmary and Broadmoor. The Secretary of State wrote to me on 6 December 2012 and asked me to ensure that my work on the themes emerging from the NHS investigations into Savile’s activities and the lessons to be learnt for the NHS also took account of the conclusions of the investigations to be carried out in relation to these other hospitals.

2.7 After processing and reviewing further evidence and information held by the MPS and passed to the Department of Health at the end of 2013, investigations into allegations of abuses by Savile were set up at further NHS hospitals.

2.8 In a letter dated 15 November 2013 (page 129 of appendix B) the Secretary of State for Health asked me to provide him with general assurance of the quality of the reports resulting from all of the new investigations beyond those at Leeds General Infirmary, Stoke Mandeville and Broadmoor. The Secretary of State also asked that the report on lessons learnt should include any learning from the new investigations.

2.9 Reports of the investigations by 28 NHS organisations into matters relating to Savile, together with my oversight and assurance report were published on 26 June 2014.¹ Sixteen further investigation reports are being published on the same day as this report.

¹ The published reports can be viewed and downloaded via the following link: <https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile>

2.10 Allegations and information which came to light after June 2014 about Savile's presence on NHS premises were investigated by the relevant NHS trust, with oversight from the NHS Savile legacy unit. The chair of that unit, Dr Sue Proctor, advised me and Ed Marsden of any themes to emerge from those investigations. We have taken account of them in writing this report.

2.11 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."

2.12 Ed Marsden and I reflect on these themes in this report.

3. Terms of reference

3.1 The terms of reference for the work described in this report were set out in the Secretary of State for Health's letter dated 12 November 2012 referred to above. They were to:

- identify the common themes from all the NHS investigation reports into matters relating to Jimmy Savile;
- look at NHS-wide guidelines and procedures in the light of the findings and recommendations of all the NHS investigation reports;
- seek relevant expert advice (if appropriate); and
- advise the Secretary of State for Health on whether and how any relevant guidelines or procedures need to be tightened or changed.

3.2 The Secretary of State for Health said he was particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role. He has expressed concern about whether or not current systems sufficiently safeguard patients.

4. Executive summary and recommendations

Executive summary

4.1 In October 2012 the Secretary of State for Health asked me to provide independent oversight of the investigations at three NHS hospitals (Leeds General Infirmary, Stoke Mandeville and Broadmoor) and the Department of Health into the associations that the late Sir Jimmy Savile OBE, (Savile), had with those hospitals and the department, and allegations that Savile committed sexual abuses on the hospitals' premises.

4.2 Following my appointment to that oversight role and in the wake of increasing concern about the nature and enormity of Savile's activities, the Secretary of State also asked me to identify the themes that would emerge from the investigations and to look at NHS-wide procedures in light of the investigations' findings and recommendations. Subsequently, I was also asked to include in my considerations the findings of internal investigations into further allegations of abuse by Savile at various other NHS hospital sites. Reports of the investigations by 28 NHS organisations into matters relating to Savile, together with my oversight and assurance report were published on 26 June 2014. Sixteen further investigation reports are being published on the same day as this report.

4.3 I have been supported in my work by Ed Marsden, managing partner of the consultants Verita. In this report we summarise the findings of the reports of NHS Savile investigations. We describe and consider the themes and issues that emerge from those findings and the further evidence we gathered. We identify lessons to be drawn by the NHS as a whole from the Savile affair and we make relevant recommendations.

4.4 Much of the story of Savile and his associations with NHS hospitals is unusual to the point of being scarcely credible. It concerns a famous, flamboyantly eccentric, narcissitic and manipulative television personality using his celebrity profile and his much-publicised volunteering and fundraising roles to gain access, influence and power in certain hospitals. He used the opportunities that that access, influence and power gave him to commit sexual abuses on a grand scale. However features of the story have everyday implications and relevance for the NHS today. These matters are considered in this report.

4.5 In light of other recent sex abuse scandals and allegations, the lessons learnt from the Savile case must form part of a wider public conversation about how all professionals and public bodies identify abuse and act to tackle it.

Methodology

4.6 During the course of our work we maintained close contact with the many NHS Savile investigation teams and with the NHS Savile legacy unit. We also had regular contact with MPS officers leading Operation Yewtree. This allowed us to identify issues and themes as they emerged during the investigation process. We have drawn on the evidence and findings contained in all the investigation reports.

4.7 Our own evidence gathering included:

- meetings and interviews with commentators, experts and practitioners;
- a review of relevant documents, articles, research literature and reports;
- a call for evidence from NHS staff;
- a programme of hospital visits; and
- two discussion events (one with historians, described below, and one with experts in sexual offending and safeguarding).

Historical background

4.8 The need to take account of the historical background to the events and issues arising in the Savile investigations prompted us to commission History and Policy² to put on a discussion event for the NHS investigation team leads and us. We wanted to gain evidence and understanding of the historical culture and circumstances that would have influenced Savile's behaviour and how others responded to him. We wanted also to gain insight into how the culture and circumstances in question have altered over time so that we could identify the lessons still relevant for today's NHS.

² History and Policy is a national network of academic historians.

Our findings

4.9 The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- 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.

Security and access arrangements

4.10 The investigation reports relating to Leeds General Infirmary, Stoke Mandeville, and Broadmoor, suggest that security at those hospitals has improved. This accords with what we learnt about how awareness of security and security arrangements elsewhere in the NHS have developed and improved in recent years, and particularly since the introduction in 2003 of a national strategy aimed at raising the standards and professionalism of security management in the NHS.

4.11 Hospitals should try to reduce opportunities for those without legitimate reasons from gaining access to wards and other clinical areas. Interviewees made plain to us however, that total restriction or control of public access across a whole hospital site is neither desirable nor achievable. Hospitals are public buildings and significant employers in their localities. The public regard their local hospital as their "facility" and they have many and varied reasons for wanting access to it.

4.12 The Leeds investigation report shows that Savile was an accepted presence at Leeds General Infirmary for over 50 years. He wandered freely about the hospital and had access to wards and clinical areas during the day and at night. The Stoke Mandeville

investigation report shows that the circumstances of Savile's access within that hospital were similar to those at Leeds General Infirmary.

4.13 In the case of most NHS hospitals, high-profile celebrity or VIP visitors are rare. Organisations told us this was why they had not thought to draw up formal policies for managing them. However, many organisations told us they hoped in future to increase their revenue from fundraising, which would entail developing associations with celebrities and VIPs. Regardless of whether they had a formal policy, most organisations told us that in practice all celebrity or VIP visitors were accompanied while on hospital premises.

4.14 The failure to draw up a policy for managing celebrity and VIP visits leaves hospital organisations vulnerable to mismanagement of approaches from celebrities and VIPs for such visits and of the visits themselves. Staff must be adequately supported to ensure that they feel able to keep relationships with VIPs and celebrities on an appropriate footing and to supervise and regulate their visits. To this end, they need clear and accepted policies and procedures.

Role and management of volunteers

4.15 Savile's relationships with Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals arose out of a number of volunteer roles: he helped with the hospital radio at Leeds General Infirmary, he was a volunteer porter at Leeds General Infirmary and Stoke Mandeville and he supervised entertainments at Broadmoor. In addition, Savile became well known for fundraising for these and other NHS organisations.

4.16 We examined whether NHS hospitals today have arrangements to ensure that volunteers are properly managed and operate within defined and acceptable parameters.

4.17 Our interviews with those involved in managing NHS hospital volunteer services not only made plain how the numbers of volunteers have increased in recent years but also how the profile of volunteers and the type of work they do have changed and expanded. Nearly all of the hospitals we had contact with told us they had plans to increase their volunteer numbers.

4.18 The scale of the volunteer presence and the extent and nature of the work they do means that the arrangements for managing volunteers, and the risks associated with their presence in hospitals, need to be robust and command public confidence.

4.19 Effective management of volunteers requires board level commitment and leadership. Organisations need to take a strategic approach to planning their volunteer schemes. Managing a scheme properly demands resources and has a cost.

4.20 The management arrangements for volunteer schemes in NHS hospitals vary widely in the commitment and resources devoted to them. Some hospitals we visited demonstrated that their volunteer schemes were overseen at board level, were subject to strategic planning processes and that their voluntary service managers had appropriate support. However we also encountered hospital voluntary services that did not appear to be strategically planned or led, and where the voluntary services manager worked in isolation with little or no connection to the wider management system of the hospital, and with little or no management or administrative support.

4.21 Hospitals told us that their recruitment processes for new volunteers included interviews and obtaining references, and in some cases occupational health checks. They also told us they undertook enhanced record checks via the Disclosure and Barring Service (DBS).

4.22 Hospitals told us that they gave new volunteers induction training. In most cases the induction training included safeguarding training but it was not always of high quality. The training volunteers receive needs to impart the values of the organisation as a whole, and the expectations and responsibilities of volunteers, including the part they play in safeguarding patients, visitors and colleagues.

4.23 There is also an issue with hospitals not requiring volunteers to have their training updated and refreshed. Volunteers should be given regular safeguarding training to ensure that they are equipped to identify safeguarding issues and respond to them appropriately.

4.24 We were impressed by the extent of volunteer schemes in NHS hospitals and the many ways volunteer schemes in hospitals improve the patient experience as well as benefiting those who volunteer and the wider community. We share the view of many we

spoke to that volunteers in NHS hospitals are a force for good. We should not place unnecessary barriers in the way of well-intentioned people who wish to volunteer in hospitals. Nevertheless, having large numbers of volunteers working in hospital settings involves risks and the Savile case has clearly highlighted the need to ensure reasonable precautions to protect vulnerable people from those who might seek to do them harm under the guise of volunteering.

Safeguarding

4.25 Social attitudes and public policy in relation to the protection of children and young people have changed and developed significantly since the time that Savile first started volunteering in NHS hospitals. In keeping with these wider societal developments, awareness among NHS staff of the issue of safeguarding and of their obligations to protect patients, especially children and young people, from abuse, harm, and inappropriate behaviour has increased markedly in recent years. There is some concern however that while staff may be aware of the issues raised by recent scandals, they may not necessarily recognise the implications of these issues for themselves and their own organisations.

4.26 All the hospitals we visited, and most of those who responded to the call for evidence, told us that all their staff, both clinical and non-clinical, received mandatory induction training that included safeguarding, with higher levels of safeguarding training being mandatory for all clinical staff working with children and vulnerable adults. Nevertheless we received evidence that not all hospitals deliver safeguarding training of a high quality. We also learnt of hospitals that did not ensure that all staff updated their safeguarding training.

4.27 Our investigations showed that numbers of dedicated safeguarding staff varied widely in different NHS hospitals and in some cases staff resources were stretched. The numbers of staff in dedicated safeguarding roles is not the only key to effective safeguarding, but it is essential that all staff should be trained to identify safeguarding issues and should be able at all times to access specialist support and advice if necessary.

4.28 We considered what makes for an effective safeguarding system from the particular perspective of trying to prevent a recurrence of events similar to the Savile case. We identified the need for hospital leadership that promotes the right values:

boards and individual leaders of organisations must be clear about their intention to take safeguarding seriously and put in place mechanisms that allow concerns to be raised and dealt with properly. Effective safeguarding requires organisations to encourage openness and listening when people, including children, raise concerns. It also requires senior staff to be approachable and well informed about what is happening in their organisations: we heard of good examples of senior managers spending time on wards and how this allowed them to pick up on issues of concern.

4.29 It is an essential part of an effective safeguarding system that safeguarding messages are reinforced through regular training and communication with staff. As part of this, organisations also need to demonstrate and give feedback to staff to show that they respond appropriately to specific safeguarding concerns.

Specific safeguarding issues

DBS checking

4.30 We looked at the current legislative framework governing record checks for those who work or volunteer in NHS hospitals.

4.31 The Disclosure and Barring Service (DBS) maintains lists of people barred from engaging in “regulated activity”. An organisation engaging staff and volunteers in “regulated activity” can access a barred list check by requiring those staff and volunteers to undertake an enhanced DBS check (previously known as a CRB check) together with a barred list check. It is unlawful for any employer to require an enhanced DBS check with barred list information for any position other than one that is “regulated activity” as defined by Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012).³

4.32 In the context of NHS hospital settings, what amounts to “regulated activity” in relation to adults differs significantly from that relating to children. With adults, only

³ An organisation engaging staff and volunteers not in “regulated activity” can only require standard or enhanced DBS checks without a barred list check if those staff or volunteers are eligible for such checks because of their activities. This includes work or volunteering with vulnerable groups including children.

those staff or volunteers with direct hands-on or close contact with adult patients can be required to undergo a barring list check, and this applies whether they undertake the activity in question once or more frequently, and whether or not they are supervised in it. With respect to children, staff and volunteers with less intimate contact can be required to undergo a barring list check but checks can only be required where the activity in question is undertaken frequently and is unsupervised.

4.33 Most of those we interviewed who had experience of safeguarding issues told us of their concerns about the present limitations on barring list checks for staff and volunteers working in NHS hospital settings and elsewhere and the risks this poses. Many staff and volunteers in NHS hospitals who do not fall within the present definitions of “regulated activity” have legitimate reasons and opportunities for being in close proximity to adult and child patients and their visitors. The concerns are compounded by the fact that people in hospital are more vulnerable and likely to be at greater risk than others from the attentions of those inclined to commit sexual assault.

4.34 The barring lists clearly do not provide a comprehensive list of all those who might pose a threat of abusing people in hospital. Nevertheless we believe it would be proportionate and justified to require all those who work or volunteer in hospitals and have access to patients or their visitors to be subject to barring list checks.

4.35 Under the present DBS system, criminal record and barring list checks on staff and volunteers are required only when they are first engaged, with no requirement for retrospective or periodic checks. It is naïve to assume that a risk based approach, rather than mandatory periodic checks, offers greater assurance in relation to record checking. Large organisations are unlikely to have the resources or the opportunities to immediately identify each employee who might at a given time present a risk to others and whose records ought to be checked. We believe there should be DBS checks on NHS hospital staff and volunteers every three years.

NHS engagement with wider safeguarding systems

4.36 We interviewed a number of chairs of local safeguarding boards. They all raised concerns about how far NHS hospital trusts engaged with local safeguarding boards and local safeguarding arrangements.

4.37 A number of interviewees raised with us their concerns about how far NHS hospitals fulfilled their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service (DBS) in respect of staff who had harmed or posed a risk of harm to children or adults vulnerable to abuse.

4.38 Local multi-agency working arrangements to protect children and vulnerable adults are compromised if NHS organisations do not share information about those who pose a threat. Equally, it undermines the barring system if NHS organisations do not refer to DBS persons who ought to be included on a barring list. We believe NHS organisations should be fully aware of their obligations in relation to these matters.

Internet and social media access

4.39 We learnt of incidents relating to the use of the internet and social media on hospital premises that raised safeguarding concerns. They caused us to question whether NHS hospitals had adequate arrangements in place to protect people in their care, particularly children and young people, from the risks posed by modern information technology.

4.40 The evidence we gathered shows that some NHS hospitals do not have a clear and consistent policy on managing internet and social media access by patients and visitors. Hospital organisations need such a policy, to protect people on their premises from the consequences of inappropriate use of information technology, the internet and social media. Without one, staff do not have the guidance and support they need to deal with difficult issues. They may also be exposed to pressure and complaints from patients and their families, some of whom may wish to use the internet and other technology in a way that could be offensive or harmful.

The management of human resources

4.41 Many people working on NHS premises, including many estates and security personnel, are employed by third-party contractors. A number of people with experience of safeguarding matters raised with us their concerns about whether contractors do in fact

follow appropriately rigorous recruitment and employment processes (including DBS checking). They also questioned whether contract and agency staff received appropriate training.

4.42 The Leeds investigation, and our own investigations, showed that in some hospitals responsibility for certain employment and human resources matters lies elsewhere than with the hospital's HR department. For instance, some contract staff are managed by facilities and estates departments. Recruitment, checking and training of staff including contract and agency staff should be managed professionally and consistently across a hospital trust. HR processes expected of third party contractors should be devised and compliance with them should be monitored by a hospital's professional HR managers. Overall responsibility for HR matters and board assurance in relation to HR matters should ultimately rest with a single executive director.

Raising complaints and concerns

4.43 The difficulties that Savile's victims had in reporting his abuse of them are evident in particular from the reports of the Leeds and Stoke Mandeville investigations.

4.44 Preventing abusive and inappropriate behaviour in hospital settings requires that victims, staff and others should feel able to make a complaint or raise their concerns and suspicions, and that those to whom they report those matters are sensitive to the possible implications of what is being reported to them and escalate matters to managers with authority to deal with them. We identified a number of specific matters, set out below, that we believe will encourage staff, patients and others to raise the alarm about sexual abuse and other inappropriate behaviours.

Policies and using the right terminology

4.45 Many people we interviewed told us that the term 'whistleblowing' to cover policies aimed at encouraging staff and others to speak out about matters of concern was unhelpful. They said the term implied a public challenge to an organisation and an assumption that the organisation or part of it would not respond positively to the matters being raised.

4.46 Most of the organisations we visited and many of those who responded to the call for evidence recognised the problem with using the term ‘whistleblowing’ and had changed the name of their policy to ‘raising concerns policy’ or were using the term ‘raising concerns’ in conjunction with ‘whistleblowing’. All NHS organisations should ensure that the title and content of their policy make clear that it applies to raising all concerns, whether or not they amount to matters some might describe as ‘whistleblowing’.

4.47 Staff should also be trained and encouraged to report any matters which indicate a risk of harm to others even if such matters appear to amount only to suspicion, innuendo or gossip.

A culture that supports and encourages people to make complaints and raise concerns

4.48 Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. People do not feel comfortable challenging those they see as in positions of authority and hierarchies within hospitals are a barrier to staff raising concerns. It is important in encouraging hospital staff to overcome or question the behaviour of others that managers are present within the hospital and approachable. Managers need to be trained to deal positively and appropriately when matters of concern are reported to them.

4.49 Another important element in encouraging and supporting staff and patients to raise concerns is for organisations to ensure that they feel protected from threats or other adverse consequences if they do so.

4.50 Many people we spoke to were certain that in relation to sexual harassment and sexually inappropriate behaviour in the workplace awareness and attitudes had improved markedly in recent times.

Providing opportunities for staff, patients and others to raise concerns

4.51 Most of the hospitals we visited demonstrated that they understood the need for flexibility in the way that staff and others can raise their concerns; that they needed to offer many and varied opportunities to ensure that they captured significant issues and concerns that posed a risk to their organisation, their patients and their staff. All organisations must continue to think imaginatively and share ideas about how they encourage feedback and the raising of concerns by staff and patients.

Mandatory reporting

4.52 Mandatory reporting of information and suspicions relating to abuse is an issue on which opinions differ and are deeply held. It would have significant implications for the way that professionals involved in safeguarding work. We do not think it is appropriate for us to come to conclusions on mandatory reporting purely in the context of the lessons to be drawn from one particular, historical, sex abuse scandal.

Fundraising and charity governance

4.53 The Savile case raises the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in fundraising for NHS organisations.

4.54 Most NHS hospitals have their own associated charities, which hold charitable funds for furthering the aims of the hospital. These are known as NHS charities. They are governed by the NHS Act 2006 as well as charity law. In most cases the hospital's board acts collectively as trustee of the charitable property given to it.

4.55 The question of the most appropriate governance structure for NHS charities has recently been the subject of a review by the Department of Health. As a result of the review the government will now permit all NHS charities to transfer their charitable funds to new, more independent charitable trusts regulated by the Charity Commission under charity law alone. However, NHS bodies will be able to continue to act as corporate

trustee of their charitable funds established and regulated under NHS legislation if they wish to do so.

4.56 Savile's charitable fundraising was undertaken via two charities, the Jimmy Savile Charitable Trust and the Jimmy Savile Stoke Mandeville Hospital Trust. These charities were separate from the NHS organisations to which they made charitable donations. Many individual charitable trusts, like those established by Savile, raise funds for NHS organisations but sit outside the governance arrangements of the NHS.

4.57 We considered how NHS hospitals and their associated NHS charities ensure that their fundraising is subject to good governance, and how they ensure appropriate management of their relationships with independent charitable trusts, such as those Savile established, and with individual donors and celebrities.

4.58 The first element of best practice in charitable fundraising is proper risk management to ensure not only the protection of charitable assets and funds raised but also the good name and reputation of the charity. In considering the risks to an NHS charity and the organisation it seeks to benefit, trustees and hospital managers must look at the hospital's and the charity's relationships with celebrities, major donors, commercial partners and other charitable organisations.

4.59 Most of the NHS organisations we had contact with did not have clear documented policies and risk assessment processes for managing these relationships and for protecting the organisation's brand and reputation. Some said they had no need of formal arrangements because of the limited nature of their fundraising activity. However we believe that staff with little or no experience of managing relationships with celebrities and major donors are at greatest risk of being "star struck" and of mishandling such relationships. They must be able to refer to guidance in a formal policy.

4.60 Nearly all the NHS organisations we spoke with said they would like to increase their income from charitable fundraising, especially given likely future pressure on budgets. In the event of increased charitable fundraising by NHS organisations, brand and reputation management and protection will become all the more pertinent.

4.61 Best practice also requires NHS charitable trusts to be managed and structured so that they act independently in the best interests of the charity and its purposes, with no

one trustee or group of trustees dominating decision making or acting other than in the interests of the charity. There needs to be a shared understanding between hospital management and the NHS charity of the service needs and priorities of the hospital. This demands good communication and constructive behaviours.

The observance of due process and good governance

4.62 Savile's involvement with Broadmoor and Stoke Mandeville hospitals was supported and facilitated by government ministers and senior civil servants. It is not within our terms of reference to investigate and pronounce on the weighty issue of when and on what terms it is ever justified for those at the heart of government to waive the machinery and procedures of good governance or invite outsiders including celebrities to engage in public service management. However, in the context of NHS hospitals, the Savile case vividly illustrates the dangers of allowing an individual celebrity to have unfettered access or involvement in management, and of not ensuring that good governance procedures are followed at all times and in all circumstances.

4.63 We make recommendations in this report aimed at dealing explicitly with some of the shortcomings in hospital governance processes at a local level that allowed the Savile scandal to occur. Ministers and officials have a responsibility to ensure that hospital managers are able to implement and adhere to these recommendations. They should not undermine the processes of good governance and local management.

Recommendations

Our recommendations for NHS hospital trusts are also addressed to Monitor and the Trust Development Authority under their duties to regulate NHS hospital trusts. Most of them are also addressed to:

- the Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of children and adults.

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- they are fit for purpose;
- volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- all voluntary services managers have development opportunities and are properly supported.

R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

R5 All NHS hospital trusts should undertake regular reviews of:

- their safeguarding resources, structures and processes (including their training programmes); and
- the behaviours and responsiveness of management and staff in relation to safeguarding issues

to ensure that their arrangements are robust and operate as effectively as possible.

R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.

5. Methodology

5.1 Throughout our work overseeing and assuring the thoroughness of the investigations at Leeds General Infirmary, Stoke Mandeville and Broadmoor and other NHS hospitals (which is described in detail in the assurance report published on 26 June 2014) we maintained close contact with the investigation teams. We also had regular contact with the NHS Savile legacy unit and with the MPS officers leading Operation Yewtree. This allowed us to identify issues and themes as they emerged during the investigation process.

The issues

5.2 The issues and themes that we felt we needed to investigate and take evidence about in order to fulfil our terms of reference are broadly:

- hospital security and access arrangements;
- NHS organisations' associations with celebrities, including the privileges and access accorded to them;
- the role and management of volunteers in NHS hospitals;
- safeguarding in hospital settings;
- raising complaints and concerns;
- fundraising and charity governance in the NHS; and
- observance of due process and good governance.

5.3 These issues formed the basis of the evidence-gathering we undertook over about 20 months commencing in January 2013.

Evidence gathering

5.4 Our evidence-gathering included meetings and interviews with commentators, experts and practitioners; a review of documents, articles, research literature and reports; a call for evidence from NHS staff; and a programme of hospital visits. We commissioned a discussion event with eight historians to look at the historical context of Savile's behaviour, and another discussion event with experts in sexual offending and

safeguarding to consider the nature of Savile's behaviour and how the risks of such behaviour should best be managed.

Interviews

5.5 We began our evidence-gathering with a series of meetings and discussions with agencies, organisations or individuals we had identified as able to give us a general understanding of the behaviour of Savile and his activities in the NHS and the requirements of effective safeguarding systems. Among this group were Peter Davis, (now former) chief executive of the Child Exploitation and Online Protection Centre and Donald Findlater, director of research and development at the Lucy Faithfull Foundation, a charity working to prevent child sex abuse. Both discussed with us the profile and methods of those who seek to sexually abuse children and what society and organisations can do to minimise the risks they pose. We also met with experts in safeguarding children and vulnerable adults, including the independent chairs of a number of local safeguarding boards and representatives of the Association of Directors of Social Services. We met with others who could tell us about specific issues. In this category were representatives from NHS Employers, who told us about recommended policy and guidance for the safe recruitment and management of staff; the chief executive and director general of the Royal College of Nursing; representatives of the Patients Association and of various groups representing the interests of particular groups of patients such as Mencap and Age UK; the chair and chief executive of the Association of NHS Charities; senior managers from the Disclosure and Barring Service; representatives of the National Council for Voluntary Organisations. A full list of those who gave us interviews is at appendix C.

5.6 We met or spoke with a number of individuals, agencies and representatives of organisations who have undertaken their own reviews or investigations into issues relating to Savile's activities. They included representatives of Her Majesty's Inspectorate of Constabulary, who in March 2013 published a report into the knowledge that police forces had of historical allegations against Savile and their responses to them⁴; the Crown Prosecution Service, who undertook a review early in 2013 of the guidance issued on the investigation and prosecution of child sex abuse cases⁵; the secretariat supporting Rt Hon

⁴ HMIC (March 2013) *Mistakes Were Made, HMIC's review of allegations and intelligence material concerning Jimmy Savile between 1964 and 2012.*

⁵ Crown Prosecution Service (October 2013) *Guidelines on Prosecuting Cases of Child Sexual Abuse.*

Ann Clwyd MP and Professor Tricia Hart's review of the NHS complaints system⁶; the chair of the "Institutions" work stream of the National Group on Sexual Violence against Children and Vulnerable Adults; the Parliamentary and Health Service Ombudsman; and Sir Robert Francis QC⁷.

Call for evidence

5.7 We wrote on 2 May 2013 to the chairs and chief executives of all NHS hospital trusts and all clinical commissioning groups and local authorities in England to make a general call for evidence from staff about the matters and issues we were investigating. Our letter, reproduced at appendix D to this report, gave a dedicated email address staff could use to send us their evidence and comments.

5.8 Eighty-three organisations or individuals responded to our call for evidence and they are listed in appendix E. Most of the respondents either gave a narrative account of their organisation's current practices and procedures or sent us copies of their policy documents relating to the issues we had raised in our letter. Two respondents raised matters they wished to speak to us about directly and we made arrangements to interview them by phone or in person.

Document review

5.9 In addition to documentary evidence, mostly in the form of written policies, sent to us in response to the call for evidence or given to us on our visits to NHS hospitals described below, we reviewed other guidance documents, reports, research literature, and articles. A list of these is set out at appendix F.

⁶ Rt.Hon. Ann Clwyd MP and Professor Tricia Hart (October 2013) *Putting Patients Back in the Picture: A review of the NHS Hospitals Complaints System*.

⁷ Robert Francis QC (February 2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Sir Robert Francis QC (February 2015) *Freedom to Speak Up; An independent review into creating an open and honest reporting culture in the NHS*.

Hospital visits

5.10 The hospital trusts we visited as part of our evidence-gathering were chosen to represent the spread of NHS hospitals in size, location, type of service offered, reputation and governance structure. We therefore visited a London teaching hospital, district general hospitals and specialist hospitals, (including a children's hospital and a mental health trust), foundation trust hospitals and hospital trusts that have not yet achieved foundation trust status. A list of the hospitals we visited is at appendix G.

5.11 Each visit took place over one or two full days and included a series of planned interviews with directors, managers and staff with governance and operational responsibility for the matters we needed to consider such as security, safeguarding, associations with celebrities, processes for making complaints and raising concerns and fundraising. Our visits also included tours of wards and other parts of the hospitals during which we talked informally to frontline staff about their experiences and views and saw for ourselves how policies and procedures translated into practice. We also made shorter visits to two other hospitals to conduct interviews about their volunteer programmes.

5.12 All the planned interviews we undertook were recorded and transcribed. We told interviewees we might name them and/or quote from their transcript in this report. Interviewees were given a draft copy of the transcript of their interview for their comments and approval.

Further evidence gathering

5.13 To help the NHS investigation teams and to inform our work on the lessons learnt, we commissioned History and Policy⁸, a collaboration between King's College London and the University of Cambridge, to put on a discussion event. Eight historians from across the country with relevant expertise considered with us the historical background to Savile's offending and his association with NHS organisations and its significance in identifying lessons for today's NHS. The details of that event are described in section 7 below.

⁸ History and Policy is a national network of some 500 academic historians and publishes historical research to demonstrate the relevance of history to contemporary policy making.

5.14 We organised a further discussion event with a number of experts in sexual offending, safeguarding and crime prevention to consider the nature of Savile's behaviour, and how best to manage the risks people like him pose. We also discussed and tested with them the findings and recommendations emerging from our work.

5.15 In addition to the evidence gathered in the way we describe above, as required by our terms of reference, this report also relies on the findings set out in the reports of Savile investigations by individual NHS hospitals. They are listed at appendix H.

The limitations of our investigations

5.16 We confined ourselves to learning lessons for and evaluating present arrangements in NHS hospitals: we have not considered arrangements in other types of settings or organisations. However most of our recommendations, although addressed principally to NHS hospital trust boards, are relevant to other hospital and care providers.

5.17 The hospitals we visited represented only a small sample of NHS hospitals but they were situated in different parts of the country and covered as wide a spectrum as possible.

5.18 Our hospital visits were supplemented by evidence received from hospital trusts in response to our call for evidence. Perhaps inevitably, those hospitals that answered the call for evidence and volunteered information mostly described their present arrangements in positive terms and suggested a high degree of awareness of the issues we asked them about, particularly general safeguarding issues. In order to redress the balance we deliberately identified and visited a couple of district general hospitals that had not responded to our call for evidence and would be described in NHS circles as "challenged".

5.19 Our visits and the information supplied under the call for evidence or gathered elsewhere made clear there is disparity between organisations with regard to their awareness of the issues thrown up by the Savile case as well as the policies, procedures and resources they have to manage those issues. Some organisations - such as the children's hospital we visited - demonstrated greater awareness of and commitment to safeguarding children than was the case in other organisations. But it needs to be

remembered that Savile's activities took place in a teaching hospital, district general hospitals and a secure hospital: all hospital organisations must understand the risks they face and mitigate them appropriately. We use this report to highlight good practice as well as the risks and weaknesses we have identified as a result of our evidence-gathering. We hope all hospitals, regardless of their specialism or other particular features of their work, will use this report to inform a critical self-analysis of their procedures.

5.20 Some issues arising from the Savile affair and relevant to NHS hospital settings have been the subject of recent investigations and reports by other people and organisations.⁹ Where this is the case, we contacted them in order to understand the parameters of their work and avoid duplication. Where pertinent to do so we refer to and rely on their work.

The naming of NHS trusts and witnesses

5.21 We visited only a small sample of NHS hospitals, chosen because they represented different types of NHS hospital in different places. The staff we interviewed formally or spoke to on visits to wards and other clinical areas were helpful and generous with their time. They gave their answers in a thoughtful and open way.

5.22 In these circumstances we think it would be unfair and inappropriate to name hospitals whose policies or practices we criticise. For the same reasons we do not identify witnesses whose evidence might attract personal criticism. Where we had concerns about the policies and practices of the hospitals we visited we discussed them with the management of the organisation.

⁹ For example, the recent review of the NHS hospital complaints system by Rt. Hon. Ann Clwyd MP and Professor Tricia Hart (October 2013) *Putting Patients Back in the Picture: A review of the NHS Hospitals Complaints System*.

6. Findings of the NHS investigations

6.1 In this section we give a broad outline of the findings and themes of the NHS investigations into matters relating to Savile. These findings and themes have informed our own investigations and our consideration of the lessons for NHS hospitals today. The reader should refer to the individual NHS investigation reports¹⁰ for a more complete account of their findings, especially in relation to issues that are specific to a particular hospital.

6.2 Savile first gained entry and a foothold in the three main hospitals with which he was associated, Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals, (“the three main hospitals”), by undertaking voluntary work. At Leeds General Infirmary this was initially by helping with the hospital radio service and he then went on to work as a volunteer porter, a role he subsequently also undertook at Stoke Mandeville. At Broadmoor he was initially invited to help put on entertainments. Savile became a regular presence at each of the three main hospitals over many years - in the case of Leeds General Infirmary, for over 50 years. Savile was a significant fundraiser for a number of projects at Leeds General Infirmary. In 1981 at the instigation of a government minister he was given responsibility for overseeing the £10m fundraising campaign for the development of Stoke Mandeville’s National Spinal Injuries Centre (NSIC). He was also given effective control of the building project for the centre, which was completed in 1983.

6.3 Savile visited many other NHS hospitals across the country, mostly on a one-off basis. He made these visits in his capacity as a celebrity to attend fundraising, prize-giving, and broadcasting events.

6.4 Savile’s involvement with the three main hospitals was encouraged and supported by senior hospital and NHS managers. In the case of Leeds General Infirmary and Broadmoor, his volunteer roles were expressly sanctioned at the highest level within those hospitals. Managers appear to have taken a positive view of his presence. They welcomed an association with a significant celebrity who could raise the profile of their hospital and

¹⁰ The reports can be accessed via the following link:
<https://www.gov.uk/government/collections/nhs-and-department-of-health-investigations-into-jimmy-savile>

might boost staff and patient morale. In due course, managers at Leeds General Infirmary and Stoke Mandeville came to appreciate and rely on his fundraising capabilities. In turn, Savile used the publicity surrounding his involvement with the hospitals and his fundraising on their behalf to gain publicity for himself and to enhance his celebrity status.

6.5 Successive management teams at the three main hospitals appear not to have questioned or assessed the risks associated with Savile's role and presence in their organisation. The NHS investigations found no evidence of any arrangements to manage or define Savile's work or his relationships with the hospitals.

6.6 The investigation reports show that security arrangements at hospitals during Savile's time were less sophisticated than they are today. Hospitals appear to have had little or no formal policy governing access by visitors and others, including celebrity visitors, on hospital premises. At each of the three main hospitals Savile had access to keys and virtually unfettered access to all parts of the hospitals including wards, and other clinical and restricted areas. At Broadmoor, a high-security mental health hospital, Savile was given his own set of keys which gave him access to ward areas, day rooms and patients rooms and he was able to reach some patient areas without supervision. At Leeds General Infirmary Savile also had the privileges of a parking space and a series of offices. At Stoke Mandeville Savile initially slept in a camper van he was allowed to park in the hospital grounds but at some stage he was given accommodation with shared facilities alongside female hospital students. At Broadmoor he had his own accommodation outside the secure perimeter of the hospital but he was able to park his camper van within the secure perimeter.

6.7 The findings we set out above indicated the need for us to examine hospital security and access arrangements, including in relation to celebrity and VIP volunteers and visitors, and the role and management of volunteers in NHS hospitals.

6.8 Officials in the Department of Health and Social Security (as it then was) acting on the wishes of government ministers put in place arrangements under which Savile became chairman of the trustees of the appeal for the development of the NSIC at Stoke Mandeville. The trustees were in effect given total control over the building development project as well as fundraising for it, and statutory and other frameworks relating to management of such a project were swept aside. In 1987, the department, which had direct management responsibility for Broadmoor, appointed Savile as a non-executive

director of the hospital board. The next year the department appointed Savile to head a task force to run Broadmoor until the establishment of a new Special Hospitals Service Authority (SHSA) in the following year. As head of the task force, Savile influenced the appointment of a friend of his to the post of the SHSA's general manager at Broadmoor. The positions granted to Savile strengthened the impression he gave to staff and managers at all the hospitals with which he was involved that he was close to government ministers, Department of Health officials and other influential people and that he was in a position of authority.

6.9 These findings raised questions about governance arrangements in NHS hospitals, particularly in relation to charity fundraising, and the role played by central government in undermining statutory or conventional governance processes and procedures.

6.10 Savile's public behaviour towards women both patients and hospital staff, was attention seeking and inappropriate. It included lewd remarks and theatrical hand and arm kissing. His behaviour in ward and clinical areas at the three main hospitals was loud and disruptive. While some staff accepted Savile's behaviour as "*just Jimmy*" and valued his fundraising and support for their hospital, many disliked him and viewed him as a nuisance, a "*creep*" and a promiscuous sex pest.

6.11 Savile's access and influence in NHS hospitals gave him opportunities to commit sexual assaults. Most of the assaults were opportunistic but some included an element of premeditation, including grooming. Some assaults were facilitated by other people. Savile's known victims ranged in age from five to 75. They included men and women, patients, staff and hospital visitors. Most victims did not tell anyone what had happened to them. Among the reasons given for this were that they thought they would not be believed because of Savile's celebrity and status in the hospital; they felt embarrassed or humiliated; they believed they would not be taken seriously; they thought they were in some way to blame; they thought it was not important enough to be reported; they had been intimidated by threats from Savile; or they feared repercussions.

6.12 A few of Savile's victims did report what had happened to them to members of staff, their relations or to senior colleagues. Mostly those reports were either not believed or were brushed aside or ignored.

6.13 During Savile's time, policies and procedures for safeguarding patients and others and internal controls for managing the behaviours of certain staff groups were lacking or deficient. At Broadmoor, there was *"an atmosphere within the hospital that tolerated inappropriate behaviour, including sexual misbehavior, and that discouraged reporting"*¹¹.

6.14 The NHS investigations found no evidence that the rumours and talk about Savile's generally inappropriate behaviour or specific reports of sexual assaults by him were ever escalated or otherwise came to the attention of senior managers. The investigation reports in part attribute this to the fact that in Savile's time hospitals were hierarchical institutions and that wards and departments tended to work in "silos", taking responsibility for managing their own affairs. Nevertheless, the Leeds General Infirmary and Stoke Mandeville Hospital investigation reports criticise senior managers for not questioning Savile's role in their hospitals and ensuring that he was adequately managed and supervised. Senior managers are also criticised for the fact that systems and processes in their hospitals were not robust enough to ensure that concerns and complaints about Savile's behaviour were escalated to them and dealt with appropriately.

6.15 The findings about Savile's behaviour and his sexual assaults indicated the need for us to examine safeguarding arrangements in NHS hospitals, the raising of complaints and matters of concern and how managers and staff respond to complaints and matters of concern.

¹¹ Broadmoor investigation report, para. 1.26

7. Historical background

7.1 We are conscious of the historical nature of the events the investigation teams looked into and the challenges this presents in drawing the right lessons for the NHS of today. Savile first started volunteering in hospital radio at Leeds General Infirmary in 1960. He was a volunteer either at that hospital, or at Stoke Mandeville or Broadmoor over the next 50 years. The earliest known incident of offending by Savile on NHS premises took place at Leeds General Infirmary in 1962. The last such incident we know of was also at Leeds General Infirmary in 2009.

7.2 The need to take account of the historical background to the events and issues arising in the Savile investigations prompted us to commission History and Policy to put on a discussion event for the main NHS investigation team leads and us. We wanted to gain evidence and understanding of the historical culture and circumstances that would have influenced Savile's behaviour and how others responded to him. We wanted also to gain insight into how the culture and circumstances in question have altered over time so that we could identify the lessons that today's NHS should draw from the Savile affair.

7.3 At the History and Policy event we received presentations from and held discussions with eight historians from across the country. Their expertise covers the culture and issues that formed the background to Savile's life, his work in the NHS and his offending on NHS premises. Among the topics aired with us were: the changing sexual culture in the period in question; attitudes (including in the press) to celebrity and privacy; the legal status of and attitudes to victims of child sex abuse; charitable fundraising and volunteering in the NHS; NHS management structures and culture in the relevant period.

7.4 We will not attempt to summarise all the evidence and analysis presented to us by the contributors to the History and Policy event¹². We think it would be helpful however to set out some of the "headline" findings and messages that we took from the event, and which informed our consideration of how Savile was able to behave as he did and the implications for present day arrangements in NHS hospitals.

¹² The presentation slides and supporting materials provided to us at the History and Policy event can be downloaded at <http://www.historyandpolicy.org/consultations/consultations/jimmy-savile-investigations>

7.5 Adrian Bingham, (reader in modern history, University of Sheffield), described to us the significant change in the sexual culture during the 1960s and 1970s. This was attributable to a number of factors, among them the liberalisation of media censorship and regulatory regimes, an expansion in youth culture and its economic prominence, and the availability of the pill. The pop music world was one of the most sexually liberated milieus. We were given evidence that some prominent figures within it demonstrated little or no regard for the sexual vulnerability of the young music fans they encountered.

7.6 The British press became increasingly intrusive from the late 1950s. Nevertheless, libel laws meant the press were still disinclined to take risks in exposing scandalous behaviour by well-known or wealthy people such as Savile. We were referred to the inhibiting effect on the press of the Sunday Mirror's reporting of the affairs of Lord Boothby in 1964, which resulted in the payment of £40,000 (an enormous sum) and the sacking of the paper's editor. The cautious attitude of the press prevailed until the 1980s when intense tabloid competition spurred editors into taking greater risks. The Sun and the News of the World began regularly to print 'kiss and tell' exposés and stories. But contemporary reports suggested that Savile had a reputation for being quick to threaten to sue any newspaper that wrote disobliging things about him. Two national newspaper editors have said they were prevented by their papers' lawyers from publishing credible evidence of Savile's crimes.

7.7 Adrian Bingham identified two further reasons for the failure of the press to expose Savile's behaviour. First, music journalists "*shared a sense of fraternity with the stars they mixed with*" and feared that they would be denied future access if they reported too much of what went on behind the scenes. Second, at least until the 1990s newsrooms were dominated by men. Sex scandals were viewed and reported on in terms of sexual titillation rather than the exposure of abuse.¹³

7.8 In relation to attitudes to the sexual abuse of women and children, Louise Jackson (reader in modern social history, University of Edinburgh), referred us to the fact that the Criminal Law Amendment Act 1885 raised the age of consent to 16 and made it an offence to have sex with a female under that age but until the present day, courts have been reluctant to believe and convict on the evidence of older child victims of sexual abuse. Dr

¹³ See Bingham, A. (June 2014) *How did he get away with so much for so long? : The press and Jimmy Savile*. Opinion Article, www.historyandpolicy.org

Lucy Delap, (reader in 20th century history and director, History and Policy, King's College, London) pointed out that little attention was paid to sexual abuse as a component of child abuse until the 1970s. She also drew our attention to the fact that, although there was greater awareness in society during the 1980s of the concept of 'sexual harassment', with some resulting changes in legislation, the sexual culture of the workplace and other institutions did not change to any significant degree until the present century.

7.9 On the subject of volunteering and fundraising in the NHS we heard from Dr Martin Gorsky (senior lecturer in the history of public health at the London School of Hygiene and Tropical Medicine) and Professor John Mohan (professor of social policy and deputy director, The Third Sector Research Centre, University of Southampton). We heard about the long tradition of according status and respect to high-profile charitable givers to hospitals and the acceptance of volunteers on hospital premises, and how this continued even after the establishment of the state-funded NHS in 1948. Until the 1980s however restrictions applied to NHS hospitals wanting to use charitable funds and direct fundraising was forbidden. From the 1980s a tighter economic climate and low capital investment in the NHS, as well as a change in the social policy environment, resulted in a greater emphasis on voluntary effort. The Health Services Act 1980 enabled health authorities to engage directly in fundraising and to use public funds to do so. The appeal to fund much-needed building works at Stoke Mandeville Hospital began in 1979 and was spearheaded by Savile. It was the first and most prominent symbol of this new attitude to fundraising. The significance of the £10m the appeal raised over three years is illustrated by setting that sum against the £40m that was the annual capital budget for the entire Oxfordshire Regional Health Authority area (in which Stoke Mandeville was located).

7.10 Dr Stephanie Snow (senior research associate, Centre for the History of Science, Technology and Medicine, University of Manchester) described for us the management structures created for the NHS in 1948, which meant that hospitals were managed by a triumvirate of a hospital secretary, a medical administrator and a matron. This reinforced existing tensions and inequalities between lay, medical and nursing authority, with medical authority overriding that of nurses and administrators. Reforms in 1974 led to greater consensus in management but the concept of general management was introduced only in 1983. It significantly increased perceptions of the legitimacy of managers' control over clinical services. The introduction of the internal market in the late 1980s and early 1990s further strengthened the role of management.

7.11 Dr Alex Mold (lecturer in history, London School of Hygiene and Tropical Medicine) considered with us the arrangements for raising complaints in the NHS. Making complaints about NHS services is now much more common than even in the recent past, with 107,259 written complaints to hospitals in 2011/12 as against 9,614 in 1971. Throughout the period that Savile was associated with the NHS complaints systems were variable and problematic. The evidence suggests that this continues to be the case. There has never been a formalised NHS-wide system for managing complaints made by staff.

7.12 The contributors to the History and Policy event told us that particular historical circumstances played into the hands of Savile and would have helped him to avoid being caught. His status and influence as a high-profile celebrity and effective fundraiser, when set against relatively weak and fragmented local management structures would have given him power in NHS organisations and some protection from criticism and doubts about his behaviour. The media world, which was smaller, less intrusive, and more restrained in Savile's day than it is now, was less likely to expose concerns about his behaviour. And a reluctance of individuals to raise allegations of sexual abuse would have been compounded by weak NHS complaints handling systems and the shortcomings in the criminal justice system in dealing with cases of sexual abuse. The unsympathetic social culture in the workplace and hierarchal structures would also have deterred employees from complaining about having been abused.

7.13 Some of the historical cultural issues and circumstances we believe gave succour to Savile's abusive behaviour in NHS hospitals are perhaps of less relevance in the more open, sexually aware and more questioning culture of today. Our consideration of the historical context of the Savile case, the evidence we gathered from the NHS as well as the awareness-raising effect of the Savile case and other cases, lead us to think that NHS organisations, now managed by individual hospital trusts and subject to greater public scrutiny, are more conscious of good governance and security concerns. We believe they would be less likely to allow a celebrity or any outside individual to gain as much power, influence and access in the organisation as Savile did. Moreover, once an allegation of sexual abuse or inappropriate behaviour on hospital premises has been aired, our investigations suggest it is now more likely to be escalated and dealt with through formal channels. We also think chances are greater that the press and media of today would look into and expose someone like Savile, whose behaviour had been the subject of rumour and conjecture for some time.

7.14 But it would be foolish to suggest that all the circumstances that allowed Savile to act as he did have been swept away over time and that all safeguards against a future Savile are now in place. Society needs to be constantly vigilant and aware of the fact that those with paedophile or deviant tendencies will seek access to and work with children and the vulnerable. Rules and procedures aimed at mitigating risks to children and vulnerable groups need to be in place at all times. Society as a whole and individual organisations still need to focus on how sexual abuse is averted or identified in the first place and how allegations of sexual abuse are investigated and prosecuted through the criminal justice system. How the NHS supports people to raise complaints and how these are handled are still matters of concern. And concerns also exist about whether NHS volunteers, celebrities, and charitable fundraisers are properly managed and whether charitable funds are subject to appropriate governance arrangements.

8. Our understanding of Savile's behaviour and the risks faced by NHS hospitals today

8.1 In order to identify lessons from the Savile affair we considered the psychological characteristics, the behaviours and motives of Savile and others who commit sexual abuses and the extent of the risks they pose. We drew on limited evidence from Savile's family and others who encountered him. We also conducted individual interviews with experts in sexual offending and safeguarding. In addition, we brought together a number of such experts for a discussion event that explored the psychological profiles and offending behaviour of Savile and other sex offenders and how the risks of sexual abuse should best be managed.

8.2 Those who attended the discussion event are named in appendix J. They commented on some of the measures that should be in place to mitigate the risks of abuse in hospitals. Their comments and observations are included in later sections of this report.

8.3 We interviewed two members of Savile's family but they offered us little insight into his personality and motivations. Savile's nephew told us he "*loved the ground [his mother] walked on*". Savile nearly died as a child and this cemented the relationship between him and his mother. According to Savile's nephew, Savile's inclination to undertake charity work was inspired by his parents who "*did a lot for charity and because he was a devout catholic*".

8.4 A number of staff witnesses in the Broadmoor investigation described Savile's personality and general, public behaviour. The investigation report sets out their evidence as follows:

"Savile could, we were told, undoubtedly be charming, persuasive and oddly charismatic, at least to some people, although others found him "a showman", "bombastic", "charmless" or "arrogant". He was self-centred, narcissistic and grandiose, talking only about himself, his achievements (real or imagined) and the 'people in high places' he knew. He was described to us as extremely manipulative but lacking in warmth or human empathy, and had no real friends. He was prone to bizarre exaggeration - for example even suggesting, we were told, that he had been the driving force behind the Major-Clinton Northern Ireland peace negotiations...In the view of someone who worked closely with him, Savile

"couldn't care less about...people...never felt sorry for anybody.." At least one psychiatrist at Broadmoor told us that she "thought he had a major personality disorder..."¹⁴

8.5 We interviewed Peter Davies, a chief police officer and formerly chief executive of the Child Exploitation and Online Protection Centre. He described how power and vulnerability were key features of grooming and abuse of children and how this applied in Savile's case. He told us:

"In Savile's case, power was celebrity; access to the corridors of power; the aura of invincibility and untouchability, and also the access to children and vulnerable people that that power was clearly diverted towards...you are investigating people in hospitals and also children and star-struck teenagers meeting one of the biggest stars of their day."

8.6 Mr Davies went on:

"sexual abuse is not solely about personal sexual gratification, but there are many psychological dynamics about power and control and status too."

8.7 We also interviewed Dr Jackie Craissati MBE, clinical director in forensic and prison services at Oxleas NHS Foundation Trust, a consultant clinical psychologist with particular expertise in sexual offending and personality disorder. She was keen to stress that a wide variety of pathways lead people to become sex abusers and that it is necessary to keep an open mind about what causes an individual to commit sexual offences.

8.8 Dr Craissati had no personal contact with Savile but she had seen the documentary film made by Louis Theroux about Savile in 2000 entitled *When Louis Theroux met Jimmy Savile*. This had suggested to her the possibility that Savile was too close to his mother and that his mother, while loving, had also perhaps stifled him. We asked Dr Craissati to offer an explanation, albeit a speculative one, for Savile's behaviour. She suggested that, as a result of his relationship with his mother, in Savile's mind most women were *"sexual and persecutory"* and could be used and attacked and were to be kept entirely separate and seen differently from his *"sacrosanct, perfect"* mother. Dr Craissati said:

¹⁴ Broadmoor investigation report, para. 6.27

"with mothers who say [women] are not good enough for you, you're special, one of the issues perhaps I think...is this issue of someone who has grown up with a sort of arrogance and specialness which means that they are entitled."

8.9 She went on:

"...there is a personality disorder coming in to play here, narcissism, essentially. You have a narcissistic man going out raising millions feeding into his ego, interacting with an interest in girls, which is a very potent combination."

8.10 Dr Craissati said Savile and the circumstances of his offending were unusual: Savile was not only highly pathological in his personality and sexual deviance but he also had extraordinary access, which gave him the opportunity to commit abuses on an unusual scale. Dr Craissati warned of the risks involved in designing preventive measures based on the experience of Savile:

"...creating policies and procedures out of the aftermath of one extraordinarily unusual man is...a nightmare for those of us who are trying to deal with the everyday normal case...it is very rare for a man to look like a paedophile, behave like a paedophile superficially and then actually be a paedophile...and to be a celebrity at the same time...it is an extraordinarily unusual situation."

8.11 Although Dr Craissati accepted the need for procedural and physical measures to protect potential victims from abuse, she cautioned that *"if you have too much of an emphasis on physical security your, what we call relational security disappears. That is that people become overly reliant on very concrete measures."*

8.12 Like Dr Craissati, Donald Findlater, director of research and development at the Lucy Faithfull Foundation, a charity that works to prevent child sex abuse, stressed that Savile's offending behaviour was unusual. He pointed to the wide variety of people Savile abused. He also said:

"I guess he is atypical in terms of sexual offenders; that doesn't mean there are not others with a similar disposition but he is at one end of a spectrum in terms of how he did it and what he did. Many sex offenders are looking for some kind of

sustained sexual behaviour with one or a few victims they are not looking for a single sexual event of abuse and then move on to the next one. Therefore that means that the process of grooming was very different, the assumptions about not being 'told on', about not being noticed, in a way the arrogance about "I will get away with this" and the assumption that would be the case."

8.13 The attendees at our discussion event, which included Dr Craissati and Donald Findlater, had differing views about the prevalence in society of people who might in fact commit sexual abuse. They also differed on the extent to which psychological factors rather than situational factors (particularly opportunity) determined or contributed to Savile's offending and to the offending of others. Nevertheless, they agreed that organisations do need to take sensible measures to protect people from abuse, in particular, they need to reduce the opportunities for those wanting to abuse. One of the attendees, Professor Richard Wortley, the director of the Jill Dando Institute told us:

"I actually don't think much can be learned by looking at the motivations and dispositions of Jimmy Savile. If you want my opinion the reason he did it was because he could, and we could debate whether he was a paedophile, whether he was a hebephile¹⁵ or we could debate whether he was after power or whatever it is. At the end of the day, he did it because he could get away with it...I think there is a real danger if we start thinking about Savile as a special case and how he can be explained by his unique motivations and dispositions and we think we can identify people like him we will solve the problem; I just think that is misguided."

8.14 He went on:

"We can try to control the pathology by, maybe, screening people and screening is useful...but it is not going to be completely successful, not by a long chalk. The thing that we do have power over is how institutions are run and the protocols they have and the way that volunteers are managed and so forth".

¹⁵ A person attracted to pubescent children.

“...if you don’t know who the Jimmy Saviles are and who they are not, then you better make sure that the roles they are undertaking have adequate supervision to stop both sexual abuse, but also physical abuse and all the other range of abuses.”

8.15 Dr Craissati warned of the need to ensure that preventive measures were aimed at tackling all types of abuse and are not focused on sexual abuse or any one type of sexual abuse. She explained:

“I think...it would be a mistake to focus just on sexual abuse, because I think [with] a lot of emotional abuse or inappropriate behaviour you don’t know what pathway it is going down...When people think they are looking for paedophiles they are going to miss more than they catch”.

8.16 Most people we spoke to, including practitioners in the NHS, experts in the field of sexual abuse and safeguarding and the historians referred to in the previous section, suggested that society was much more aware of the issues relating to sexual abuse than had been the case in previous times. The matter is more frequently discussed in the media than in Savile’s day. Operation Yewtree had enormous publicity and resulted in large numbers of people coming forward to make allegations of historical sexual abuse. Our visits to NHS hospitals and the responses to our call for evidence indicated that NHS organisations were alive to the risks of abuses on their premises. Furthermore, as the individual hospital investigation reports make clear, NHS hospitals now have more robust local management and governance arrangements, making it less likely that an individual could exercise the same influence as Savile or gain the access and opportunities he had to commit abuses. Nevertheless, when we discussed with Peter Davis the likelihood of a repetition of events along the lines of the Savile case, he said:

“It is still true to say that between 60 and 90 per cent of all sexual abuse of children goes undisclosed to anybody according to NSPCC figures, and there are many examples. For example there are some localised grooming cases - Rochdale, Rotherham and Oxford and so on - where victims don’t even realise they are victims until they are quite a long way into a cycle of being victimised. Many victims don’t have the confidence or know how to disclose to anybody. Against that current background I find it very hard not to believe that we can just say that times are different now and it could not happen again. I think it still could, although it is less likely now we have heard of Savile. In my view there is

absolutely no sense in which we can say "well that couldn't happen now" because all the different elements are still happening."

8.17 Detective Superintendent Paul Sanford, deputy lead on child abuse at the Association of Chief Police Officers (ACPO), supported Peter Davies's view of the present risks of child abuse. He told us:

"...from this work we are doing in our office at the moment, some of this isn't unique to the health setting, it is carried across institutions and it is not all historic. It is happening now and there is a real danger in some of the commentary that has gone on recently that takes us back to saying this is something that happened in the '70s and '80s, and that breeds complacency. It is very dangerous..."

8.18 Similarly, Peter Saunders, chief executive of the National Association for People Abused in Childhood (NAPAC), told us:

"Not all abusers like Savile are dead and buried. There are very many out there still and we need to tackle that problem...abuse is a very real and present scourge in our society."

8.19 Our discussions made us aware of the unusual nature of Savile's offending behaviour. Our discussions and the investigation reports also highlighted the unusual and historical set of circumstances that allowed Savile to use his celebrity and fundraising to gain influence and access in NHS organisations and gave him opportunities to commit abuses on their premises. But we believe there is still a likelihood of other individuals, including those in charitable or volunteer roles, seeking to take advantage of the opportunities NHS hospitals present for committing abuses against children and other vulnerable people, or of using their engagement with NHS hospitals for the purpose of self-promotion or for gaining inappropriate influence. We accepted the warnings we were given about measures aimed only at preventing a repetition of the Savile case rather than measures aimed at tackling abuse in the widest sense. We also took account of the dangers of organisations relying too heavily on physical and procedural security measures, rather than developing the right cultures and behaviours to mitigate the risks of abuse.

9. Findings, comment and recommendations on identified issues

9.1 The findings of the separate NHS investigations about the cultures, behaviours and governance arrangements that allowed Savile to gain access and influence in the various NHS hospitals, and gave him the opportunity to carry out abuses on their premises over many years are strikingly consistent. The common themes and issues that have emerged from the investigations' findings which we see as relevant to the wider NHS today can be grouped under the following general headings:

- 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
- the observance of due process and good governance.

9.2 In order to assess how the NHS deals with these matters today and the adequacy of present guidance and procedures in relation to them, we relied not only on the reports of the various NHS investigations but also on evidence we gathered ourselves, including our visits to hospitals across the country, and from the responses to our call for evidence.

9.3 In this report we deal in turn with each of the themes and issues we refer to above.

9.4 Our recommendations for NHS hospital trusts are also addressed to Monitor and the NHS Trust Development Authority under their duties to regulate NHS hospital trusts. Most of the recommendations are also addressed to:

- the Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of children and adults.

9.5 Non-NHS hospital and care organisations should consider this report and implement any of our recommendations relevant to their services.

10. Security and access arrangements

Improvements in security arrangements

10.1 The Leeds investigation concluded that security at Leeds General Infirmary during the early part of Savile's association with that organisation was "*rudimentary*". It heard accounts of keys to secure areas being kept in unlocked cupboards and concluded that Savile probably had access to them. The investigation at Stoke Mandeville found that the hospital "*operated on an open access policy throughout the 1970s and 1980s.*" Wards were unlocked and the organisation "*did not have security or controlled access as part of either its culture or working practice. The environment was large, open and difficult to observe*"¹⁶. From the time that Savile first started working as a volunteer porter at the hospital he had "*free and unsupervised access to most clinical and non-clinical areas within the hospital.*"¹⁷

10.2 Similarly, the Broadmoor investigation report describes security arrangements at Broadmoor Hospital at the time that Savile first volunteered as "*primitive*". Their report concludes that "*for a considerable part of Savile's period of association with [Broadmoor], and certainly up to the 1990s, it was possible for him to access ward areas without 'checking in' either with ward staff or at the separate entrance area to the female wing*".¹⁸ It also says that Savile's "*unrestricted access to secure and clinical areas of the hospital remained unchallenged for many years*".¹⁹

10.3 One security manager told us about her experience of the management of security when she started working at a London hospital in 1991: "*There were no controls, no policies and procedures, so it has moved on dramatically*". And members of the security team at another hospital told us that their hospital's contract with its security provider 15 years earlier had mainly been concerned with protection of property, equipment and cash whereas now it focused more on the safety of patients and staff.

10.4 The investigation reports relating to Leeds General Infirmary, Stoke Mandeville, and Broadmoor, suggest that security at those hospitals has improved. This accords with

¹⁶ Stoke Mandeville investigation report, paras. 11.78 and 11.82

¹⁷ *Ibid*, para. 11.87

¹⁸ Broadmoor investigation report, para. 6.13

¹⁹ *Ibid*, para. 6.17

what we learnt about how awareness of security and security arrangements elsewhere in the NHS has been developed and improved in recent years, and particularly since the introduction in 2003 of a national strategy aimed at raising the standards and professionalism of security management in the NHS.²⁰

10.5 Staff at all the hospitals we visited wore identification badges. So long as badge holding is properly authorised and monitored, badges provide staff, patients and visitors with a quick and easy means of checking and being reassured that someone has the right to be on hospital premises.

10.6 Many hospitals told us they now have locked wards, with staff able to gain access with swipe cards or electronic proximity readers. Cards and readers are programmed to give staff access only to wards and departments they need to access. These security systems have the advantage that areas can be 'locked down' if necessary. Other hospitals have locked wards with access by entering numbers on a keypad.

10.7 Some hospitals do not have the level of physical security we refer to. One hospital we visited introduced measures to control access within the hospital only in the last three or four years and at the time of our visit in 2013 it applied only to certain wards such as maternity and to the wards in a new building.

The limitations of physical security measures

10.8 No doubt it is sensible for hospitals to try to reduce opportunities for those without legitimate reasons from gaining access to wards and other clinical areas. Interviewees made plain to us, however, that a total restriction or control of public access across a whole hospital site is neither desirable nor achievable. Hospitals are public buildings and significant employers in their localities. The public regard their local hospital as their 'facility' and they have many and varied reasons for wanting access to it. It is desirable that hospitals are accountable and open to the scrutiny of the communities they serve. Peter Allanson, trust secretary and head of corporate affairs at Guy's and St. Thomas' NHS Foundation Trust said his hospital:

²⁰ Department of Health and NHS Counter Fraud Service (December 2003) *A Professional Approach to Managing Security in the NHS*.

“is a public building, you want it to be reasonably welcoming, and part of the community...it fails if it isn't and you have a corporate social responsibility to this community to its citizens...and being part of the South Bank.”

10.9 Even restricting access at ward level via the sort of entry systems we refer to can be problematic because closed wards require staff to open doors or to operate a buzzer entry for visitors and others without passes. At busy times this can be time-consuming and disruptive. Security staff at one hospital we visited acknowledged that while all their wards should be locked, at certain times the doors were kept open on some wards to make access freer for visitors.

10.10 Even where doors are locked, unauthorised people may still gain access by 'tailgating' - slipping through a door when it is opened by or for others. Staff at one hospital gave us a recent example of two people entering a ward by tailgating. They were challenged by staff and ultimately detained by the police.

10.11 In any event, as we observe above, hospitals need to be accessible to some degree, and their security systems will always rely on individual staff to ensure those systems operate properly. As one associate director of nursing put it:

“I think in a hospital security is always a challenge as there are so many entrances and back doors. The wards and clinical departments are locked but it is making sure that people lock them down at night. If people do walk on to wards, I would expect them to be challenged by staff saying “can I help you”.

10.12 In addition to physical security measures and sensible restrictions on access, hospitals should put in place proper staff training aimed at highlighting the vulnerability of security systems, and the need for all staff to see it as their business to challenge those not wearing security badges or about whom they have concerns or suspicions. We were reassured to hear from a number of interviewees that these matters were a feature of their hospital's training programmes.

Celebrity and VIP access arrangements

10.13 The Leeds investigation report shows that Savile was an accepted presence at Leeds General Infirmary for over 50 years, and was *“able to move freely around the Infirmary at all hours of the day or night...”*²¹ He had access to areas of the hospital and its services *“that would be highly unusual for any porter, especially a voluntary one.”*²²

10.14 The Leeds investigation team found that Savile *“would often make unannounced visits to wards and departments. His visits included the accident and emergency resuscitation room, visiting wards to accompany clinical staff in wards rounds, and we had one report of him assisting a nurse in giving a child who was an in-patient, in intensive care, a bed-bath.”* They came to the view that *“this level of access was available to Savile on account of his celebrity status rather than his role as a volunteer porter”*²³. They concluded that *“...no senior manager appeared to have responsibility for ‘minding’ Savile in the Infirmary, as would be commonplace with visiting celebrities today. Savile’s day-to-day presence at the Infirmary had become ‘invisible’ to those in charge. In addition, to many staff on wards and departments, he was regarded as ‘part of the furniture’”*.²⁴

10.15 The Leeds investigation team also found that at the time they began their investigations the Leeds Teaching Hospitals NHS Trust had no *“policies or procedures governing access to hospital premises by celebrities and media crews, i.e. those who could be seen as ‘sanctioned visitors’”*.²⁵

10.16 The Stoke Mandeville investigation report shows that the circumstances of Savile’s access within that hospital were similar to those at Leeds General Infirmary. The Stoke Mandeville investigation team found:

“The lack of management and monitoring of Savile is key to the issue of his access, permissions and privileges. He was accepted into the Hospital and set down in the middle of a busy and sprawling organisation with a myriad of cultures, customs and practices. In this kind of environment Savile was able to go

²¹ Leeds investigation report, page. 84

²² *Ibid*, page. 86

²³ *Ibid*, page. 86

²⁴ *Ibid*, page. 106

²⁵ *Ibid*, page. 181

about his business, not only unchallenged, but also with the perception of sanction from the senior hierarchy".²⁶

10.17 The investigation team concluded that senior managers were remiss because:

"A celebrity volunteer was allowed unmanaged, unmonitored and unsupervised access to an NHS site and the patients, staff and visitors within it over a period of many years, with no monitoring or management in place."²⁷

10.18 The Stoke Mandeville investigation team found too that:

"Buckinghamshire Healthcare NHS Trust had no procedure in place specifically to manage VIP or celebrity visitors. It is currently updating its volunteer and visitor policy to include procedures for all celebrities and VIPs, including politicians, who may visit the organisation. It will become a tenet of basic Trust policy that every VIP or celebrity, regardless of their status, will be treated in the same rigorous manner as all other visitors to the Trust".²⁸

10.19 We took evidence from staff at two hospitals in London that regularly receive visits from high profile celebrities or politicians. Both had clear, well-tested policies for deciding whether or not such high-profile visits ought to take place and the arrangements to manage them. The policies included a requirement that such visitors be accompanied at all times by staff of appropriate seniority and that consideration be given to other safeguarding implications of such visits. We were reassured to learn that the requirement that VIPs be accompanied at all times (which serves to protect both the visitor in question as well as the hospital and its patients) was strictly enforced.

10.20 Reports of the Savile investigations undertaken at other hospitals show, however, that at the time of the investigations, most of the organisations in question did not have formal written policies for planning and managing visits by celebrities and VIPs or for supervising celebrities and VIPs on hospital premises. This is mirrored by what hospital trusts told us in response to our call for evidence and in what we found at the other hospitals we visited.

²⁶ Stoke Mandeville investigation report, para. 11.110

²⁷ *Ibid*, para. 11.113

²⁸ *Ibid*, para. 14.12

10.21 In the case of most NHS hospitals, high-profile celebrity or VIP visitors are rare.²⁹ Organisations told us this was why they had not thought to draw up formal policies for managing them. However, many organisations told us they hoped in future to increase their revenue from fundraising, which would entail developing associations with celebrities and VIPs. Regardless of whether they had a formal policy, most organisations told us that in practice all celebrity or VIP visitors were accompanied while on hospital premises.

10.22 The failure to draw up a policy for managing celebrity and VIP visits leaves hospital organisations vulnerable to mismanagement of approaches from celebrities and VIPs for such visits and the visits themselves. Staff must be adequately supported to ensure that they feel able to keep relationships with VIPs and celebrities on an appropriate footing and to supervise and regulate their visits. To this end, they need clear and accepted policies and procedures. Staff at one of the two London hospitals we refer to above gave us good examples of when they had been able to rely on formal policy to insist that VIP visitors were escorted at all times.

10.23 While most hospitals may not have many or indeed any visits from high-profile visitors almost all hospitals receive visits from 'lesser', more local celebrities and VIPs, for example local politicians and local news film crews. We were concerned to find at two hospitals we visited that local film crews were not appropriately escorted.

10.24 We recommend that all NHS hospital organisations develop a policy for managing visits by celebrities, VIPs and other official visitors. It should be made clear in the policy that it applies to all visits by such visitors whoever they may be.

Recommendation

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

²⁹ Amanda Witherall, the chief executive of the Association of NHS Charities (which represents the 92 NHS charities that raise approximately 90-95% of all NHS charitable funding) estimated for us that less than 10 of their member charities work with celebrities.

11. Role and management of volunteers

11.1 Savile's relationships with Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals arose out of a number of volunteer roles: he helped with the hospital radio at Leeds General Infirmary, he was a volunteer porter at Leeds General Infirmary and Stoke Mandeville and he supervised entertainments at Broadmoor. In addition, Savile became well known for fundraising. Acting as a volunteer, he oversaw the £10m appeal to rebuild the National Spinal Injuries Centre at Stoke Mandeville and he took part in fundraising activities at many other hospitals around the country.

11.2 Reports on the investigations at Leeds General Infirmary, Stoke Mandeville and Broadmoor hospitals make clear that Savile went on to use his volunteering, fundraising and celebrity status to widen his roles and influence in those hospitals and to obtain a degree of access beyond any that should have been accorded to a volunteer. We examined whether NHS hospitals today have arrangements to ensure that volunteers are properly managed and operate within defined and acceptable parameters.

The extent and purpose of volunteering in the NHS today

11.3 Research in 2013 by the charity The King's Fund on behalf of the Department of Health into the scale and impact of volunteering in acute trusts in England indicates significant variations between trusts in their volunteer numbers but on average acute trusts in England had 471 volunteers who offered their time at least once a month. This equates to more than 78,000 volunteers across 166 acute trusts, contributing more than 13 million hours per year to the acute sector.³⁰ These figures did not include the contribution to acute trusts by volunteers undertaking governance roles. Trusts' average spend on managing and training volunteers was £58,000 and based on the hours that their volunteers contributed, the researchers estimated that their activities represented an 11-fold return on the money acute trusts invested in their volunteer programmes.

³⁰ Galea, A, and others (November 2013) *Volunteering in acute trusts in England; Understanding the scale and impact*. London: The King's Fund p.12

11.4 The research also showed that most acute trusts envisaged a significant expansion in the number of volunteers within the next three years, in many cases by more than 25 per cent.³¹

11.5 All the hospitals we visited had large volunteer programmes. One district general hospital had 250 registered volunteers who gave 1,400 hours service per month, another had 350 who gave 4,000 hours per month. A large teaching hospital told us they had 600 active volunteers who gave 75,000 hours service per year. The largest volunteer programme we found was at King's College Hospital NHS Foundation Trust in London (King's). The head of volunteering told us they had 1,500 volunteers who gave a total of 5,500 hours per week to their four hospital sites. Nearly all the hospitals we spoke to said they would like more volunteers.

11.6 Our interviews with those involved in managing NHS hospital volunteer services not only made plain how the numbers of volunteers have increased in recent years but also how the profile of volunteers and the type of work they do have changed and expanded.

11.7 The traditional stereotype of the older, white, female volunteer is no longer accurate. The voluntary services managers we spoke to told us that the average age of volunteers in their hospitals had dropped significantly as more people, especially young people, saw volunteering as an opportunity to gain employment skills and enhance their CV. Volunteering in a clinical setting has become a necessary qualification for entry to some clinical education courses, while many unemployed people see volunteering as a step on the ladder back into employment. More men and more people from black and ethnic minority backgrounds are volunteering. At Birmingham University NHS Foundation Trust 35 per cent of 600 volunteers were men, 50 per cent were under 50 and 38 per cent came from black and ethnic minority backgrounds. Carol Rawlings, associate director of patient affairs at the hospital told us:

"As an organisation we have made an effort to reach out to other communities. What we wanted to do really was reflect the community of the patients within our hospital..."

³¹ This is in keeping with the Department of Health's strategic vision for volunteering *Social Action for Health and Well-being; Building Co-operative communities* (2011).

11.8 The profile of those who volunteer as part of the programme at King's is perhaps untypical and no doubt owes a lot to the size of the programme and the fact that King's is a major teaching hospital in South London. However Katherine Joel, the head of volunteering at the hospital, said:

"We are a very young and a very diverse service. The vast majority are students between 16 and 21. 70 per cent of our volunteers are under 30, though we do have some volunteers who are retired. And 68 per cent are from BME background, which is over representative of Camberwell."

11.9 She also told us that 20 per cent of their volunteers were men.

11.10 This increasing diversity of hospital volunteers is in keeping with the findings of the King's Fund research mentioned above. Sixty-six per cent of the respondents to the survey used in that research said volunteers tended to be younger people and 56 per cent said they were more ethnically diverse.³²

11.11 Many, perhaps most, volunteers still undertake traditional roles such as meeting, greeting, guiding and signposting patients and visitors, serving in hospital shops, operating tea and library trolleys, pushing wheelchair patients, helping to organise entertainments but the hospitals we visited described how the roles of volunteers had widened in recent years. Volunteers were increasingly undertaking roles that involved closer interaction with patients, and perhaps more directly enhanced the patient's hospital experience and more closely supported their care. We heard of volunteers helping patients to eat, helping with exercise therapies, cuddling babies, playing with children, reading to coma patients, befriending patients and offering information and peer support. Fiona Skerrow, voluntary services manager at Hull and East Yorkshire NHS Trust, told us that the services of volunteers at her hospital could now be encapsulated by the slogan *"Volunteers don't just make tea, they make a difference"*. She said *"That's what we have used throughout my time here, because they do make a difference"*. Carol Rawlings, chair of the National Association of Voluntary Services Managers (NAVSM) - the membership body for voluntary services managers in the NHS - and associate director of patient affairs at University Hospitals Birmingham NHS Foundation Trust told us that without volunteers in the NHS *"there would be a huge gap...of course our professional staff are there to undertake*

³² Galea, A, and others (November 2013) *Volunteering in acute trusts in England; Understanding the scale and impact*. London: The King's Fund p.5

specific roles but the volunteers are able to do some of those things that add value to [those] role[s] that healthcare professionals may not necessarily have time to...do."

11.12 The justification for and potential benefits of voluntary service schemes in NHS hospitals was perhaps best summed up by the managers of the volunteer programme at King's. They explained that the ethos of their present programme arose from work in 2009 to develop the trust's organisational values. These focused above all on improving the experience of patients. Volunteers were seen as able to make an important contribution to that aim. Jane Walters, the director of corporate affairs told us:

"We knew that there were all sorts of things that our patients said they wanted, but our staff are so hard-pressed they didn't have time to provide, and it was the added value...It's not about volunteers doing things that paid staff should be doing".

11.13 The volunteer programme also helps to make a difference in the hospital's local community, as Jane Walters explained:

"...the ethos is very much to try and bring the community and the hospital closer together, to provide opportunities for people in the area to get engaged with their local hospital, but essentially, to be a bit of a deal...we value the time that you are prepared to give to help our patients, and in return we will give you opportunities...for interesting roles. We will give you access to training and support, and, hopefully, a pathway through to further education or employment if that's what people want to do."

11.14 At King's and elsewhere a number of staff had been offered employment having started working as a volunteer.

11.15 Jane Walters also referred to the role that volunteers at King's played in ensuring that the hospital was open and transparent in the way it operated and more accountable to and engaged with its community, in keeping with its status as a foundation trust. King's has volunteers on all except one ward, including on the intensive care ward. Ms Walters said:

“We all know about the Francis report, and we all know how important it is to have eyes and ears constantly around in the hospital. I think we saw [volunteers] as another opportunity to make sure that we had openness and transparency of all our clinical areas.”

11.16 The values and principles underpinning the volunteer scheme at King’s were echoed in what we were told by staff at the National Council for Voluntary Organisations (NCVO), the national organisation that champions and supports volunteering and civil society. Kristen Stephenson, the volunteer management and good practice manager at NCVO said:

“...one of the core principles of volunteering is that there is a mutual benefit there and, obviously, that is at the centre of the nature of volunteering, so that...of course there is benefit to adding value to the services and what the NHS does...whether that is improving patient experience or whether it is better social interaction for patients or whether it is about bringing people from the community into the hospital, [but] it is [also] going to be that it helps develop skills in the community, it provides opportunities for people to learn, it opens up the institution. I think there is an element of looking at the broader picture of what benefit volunteers bring to the organisation and also what benefit volunteering can have for people...there has been research that has...demonstrated that volunteering can benefit health and well-being”.

11.17 Prior to the research on the scale and extent of volunteering in acute hospitals referred to above the Department of Health had commissioned the King’s Fund to research and report on volunteering across the health and social care sector. That report concurs with the view that volunteers contribute to improving patient experience in hospitals and build closer relationships between services and communities. It also identifies the benefits brought to the sector from the part volunteers play in tackling health inequalities and promoting health in hard to reach groups, and in supporting integrated care for people with multiple needs.³³

³³ Naylor, C. and others (March 2013) *Volunteering in health and care; Securing a sustainable future*. London: The King’s Fund. p.1

The management of volunteers

11.18 Given the scale of the volunteer presence and the extent and nature of the work they do in NHS hospitals, as well as the potential for further benefit to the NHS from volunteer schemes, arrangements for managing volunteers, including the risks associated with their presence in hospitals, must be robust and command public confidence.

11.19 Staff at NCVO made clear that effective management of volunteers requires strategic, board level commitment and leadership. Kristen Stephenson told us:

“a message that we consistently push is that if volunteers are going to be involved more within public services, and especially within the NHS, then there needs to be that strategic, top-level commitment...to [ensure] good volunteer management and to make sure that it is resourced...that top-level strategic commitment ...should be owned by the board like any other strategy in the organisation is. They should be as responsible for delivering on the volunteering strategy as any other element that they might performance manage.”

11.20 Ms Stephenson pointed out that beneath the strategy organisations need to have a clear volunteering policy.

11.21 Researchers at the King’s Fund describe the need for organisations to take a strategic planning approach to volunteering as follows:

“The importance of a strategic approach to volunteering is that it encourages providers to articulate how working with volunteers will help the organisation to meet its core objectives, and thereby helps to give volunteering a prominent and useful role within the organisation.”³⁴

³⁴ Naylor, C. and others (March 2013) *Volunteering in health and care; Securing a sustainable future*. London: The King’s Fund. p.17

11.22 All those we spoke to about volunteering in NHS hospitals, as well as the researchers at the King's Fund, acknowledged that the proper management of a volunteer scheme demanded resources and had a cost. The King's Fund researchers said:

*"To get the most out of volunteering, organisations need to invest in managing volunteers and ensuring they are supported and well motivated"*³⁵

11.23 Is Szoneberg, director of volunteering operations at CSV, told us:

"I think that there is still the view that volunteering is free. However, if you are going to do it properly it costs money because you need proper processes, good practice, procedures, oversight and all the other things that...you need if you are employing staff...you still need a lot of those bits of structure around it in order for it to function properly, and in order for [volunteering] to be effective and meaningful for the volunteer and for those who are receiving help."

11.24 And Kristen Stephenson of NCVO told us:

"Not only do you have the staff costs and the management costs, you have your volunteer training costs, potentially you the have costs for expenses of volunteers, you might then have costs around communications with your volunteers, newsletters, emails, whatever that might be, admin costs, CRB checks."

11.25 Ms Stephenson and her colleagues at NCVO said the extent of the resources required to operate a successful volunteer scheme depends on the scale of the volunteer programme in question and the types of roles that volunteers are undertaking. Nevertheless, they and others we spoke to agreed that appropriate management of volunteers in NHS hospitals and the management of the risks associated with their work requires robust recruitment and selection, appropriate training, supervision and management of volunteers.

11.26 It was clear from our investigations that the management arrangements for volunteer schemes in NHS hospitals vary widely in the commitment and resources devoted to them and in their robustness. Some of the hospitals we visited, including two smaller

³⁵ Naylor, C. and others (March 2013) *Volunteering in health and care; Securing a sustainable future*. London: The King's Fund. p.18

district general hospitals, demonstrated that their volunteer schemes were sponsored and overseen at board level, were subject to strategic planning processes and that their voluntary services managers had appropriate management and administrative support. The volunteer scheme at King's is of strategic importance to the organisation, is overseen at board level and has significant resources committed to it. Their head of voluntary services is supported at their Denmark Hill site by a team of two recruitment managers, two recruitment coordinators and a part-time administrator and at another site by a full-time manager and a part-time administrator.

11.27 At the other end of the scale, we encountered voluntary service managers working in relative isolation with little or no connection to the wider management system of the hospital and with little support. We heard of some voluntary services managers who undertook that role as part of a wider portfolio. One voluntary services manager with a large number of volunteers told us that she had become part of the hospital's facilities directorate as a result of recent management changes and had no engagement with board-level directors. Furthermore, she shared cramped offices with two others and the only assistance she had was six hours a week from a volunteer administrator. This meant that she spent most of her time on the administration necessary for the recruitment, checking, training and arranging placements for volunteers; she had little if any time to go into the hospital to oversee and manage the wider operation and development of the volunteer scheme. Her total budget for managing 250 volunteers was about £9,000 a year. She said: *"To have a voluntary services manager in place you really do need to support them, and there are a lot of us who aren't."*

11.28 Hospitals told us that their recruitment processes for new volunteers included interviews and obtaining references, and in some cases occupational health checks. They also told us they undertook enhanced record checks via the Disclosure and Barring Service (DBS). Most of the hospitals that responded to the call for evidence told us that in line with the relevant legislation they undertook checks only against the DBS's lists of people barred from working with adults or children (the barred lists) if the volunteer was engaged in 'regulated activity'. They also said that they undertook DBS checks only at the time of recruitment but not thereafter.

11.29 Some hospitals told us they had encountered resistance from some groups of long-standing volunteers to undergoing DBS checks. The Savile case clearly shows that being a volunteer over many years is no guarantee of a person's suitability to undertake such a

role. Moreover, as Mark Devlin, the former chief executive of Medway NHS Foundation Trust pointed out to us, hospital staff tend to place a greater degree of trust in long-term volunteers, which may heighten the need to ensure that such volunteers are subject to periodic checks. Mr Devlin said:

“ ..as a volunteer in any capacity, whether it's with a tea trolley or in a shop, you are in a trusted capacity.....you become a familiar face in the organisation and then people will probably...keep a door open for you because it is always “Oh, its that lady from the shop. She's fine” So it's the familiarity thing isn't it. That people trust familiarity and familiar faces”.

11.30 We set out in greater detail in section 12 below why we believe that the definition of 'regulated activity' should be expanded so that all NHS hospital staff and volunteers (including volunteers provided by third party organisations) who come into contact with patients and their visitors are subject to enhanced DBS checks including checks against the barring lists, and that such checks should be undertaken on a periodic basis. We say here only that we believe that hospitals that do not undertake such checks on their volunteers are placing patients, visitors and their workforce at unnecessary risk.

11.31 Hospitals told us that they gave new volunteers induction training. This involved participating in general hospital induction sessions and in local induction on the ward or in the department to which the volunteer had been assigned. However, at one hospital we visited induction training amounted to no more than a one-to-one session with the voluntary services manager and volunteers did not take part in the hospital's general induction for staff or receive training in safeguarding. Volunteers should be given induction training that imparts the values of the organisation as a whole, and the expectations and responsibilities of their role. This should include the role they play in safeguarding patients, visitors and colleagues.

11.32 Safeguarding featured in the training undertaken at the other hospitals we visited and those that responded to our call for evidence but in some cases it took the form of an online module to be completed by the volunteer in their own time.

11.33 Some of the hospitals we had contact with did not require their volunteers to undergo refresher training. Carol Rawlings, chair of NAVSM, acknowledged that the failure of hospital organisations to retrain their volunteers is a problem. In response NAVSM

produced a document in early 2013 in conjunction with Skills for Health³⁶ on training for volunteers that sets out the matters on which volunteers should receive training and how often it should be updated³⁷.

11.34 Many volunteers now undertake roles that bring them into close contact with clinical teams and with patients. Many volunteer roles require volunteers to develop relationships of trust, confidence and friendship with patients and their carers. These relationships may lead to the sharing of information and concerns including some that might indicate abuse and other safeguarding issues. If such information and concerns are to be dealt with properly and not brushed aside, as was the case with concerns raised by some of Savile's victims, volunteers should be given regular safeguarding training to ensure that they are equipped to identify safeguarding issues and to respond to them appropriately, including escalating matters to senior staff.

11.35 At most hospitals we had contact with, supervision of volunteers was the responsibility of the manager of the ward or department where the volunteer had been assigned. A number of interviewees said levels of supervision of volunteers varied significantly depending on the manager in question, and many people pointed out that whatever the arrangements for supervising volunteers they could never be watched over all the time.

11.36 Research undertaken in 2012 sought to identify risk factors in relation to the ways in which sex offenders become part of organisations and to propose good practice to safeguard children against abuse. In their report the researchers refer to a number of organisational factors (as described by the offenders who participated in the research) which may have contributed to an environment in which abuse could occur.³⁸ Among these were:

- recruitment procedures were not rigorous;
- selection processes such as interviews were not particularly challenging;
- insufficient screening of references;

³⁶ Skills for Health is the sector Skills Council for health. It helps the UK health sector develop its workforce.

³⁷ NAVSM (2013) *Guidelines for Volunteer Induction, Statutory and Mandatory training*

³⁸ Erooga, M. and others (2012) *Towards Safer Organisations II. Using the perspectives of convicted sex offenders to inform organisational safeguarding of children*. London: NSPCC

- failure by the organisation to provide clear indicators of its commitment to child welfare; and
- the organisation not being clear about the importance of rules and regulations.

11.37 In response the researchers make suggestions for ensuring that recruitment and selection processes are rigorous. They also comment on the need for proper induction:

“Induction is an important element of the process of an individual joining an organisation. As well as an opportunity to introduce new joiners to the practicalities of their new role it is also an important opportunity to introduce them to the organisation’s vision, aspirations and expectations of all staff about working with children and what is acceptable and what is not.”³⁹

11.38 The researchers say, however, that the protection of vulnerable people goes beyond matters of recruitment, selection and training of staff:

“The single most important message from this research is that the common focus of deterring or preventing “paedophiles” from joining organisations is not sufficient to appropriately safeguard children. As well as providing appropriate “barriers” by way of selection and screening processes it is also necessary to manage organisational processes so that the possibility of inappropriate or abusive behaviour developing or occurring is minimised”⁴⁰

11.39 They refer to an earlier literature review by the same team that:

“...underscored the importance of organisational culture and values on individual behaviour in the workplace, highlighting that in organisations where abuse has taken place there has frequently been a lack of appropriate infrastructure; absence of vigilance in both recruitment and on-going supervision; and a lack of culture and processes where whistle-blowing can take place.”⁴¹

³⁹ Erooga, M. and others (2012) *Towards Safer Organisations II. Using the perspectives of convicted sex offenders to inform organisational safeguarding of children*. London: NSPCC. p.12

⁴⁰ *Ibid* p.11

⁴¹ *Ibid* p.15

11.40 We believe that the findings and comments of the researchers mentioned above are equally applicable to volunteers in NHS hospitals.

11.41 We were impressed by the extent of volunteer schemes in NHS hospitals and the many ways volunteer schemes in hospitals improve the patient experience as well as benefiting those who volunteer and the wider community. We share the view of many we spoke to that volunteers in NHS hospitals are a force for good. We should not place unnecessary barriers in the way of well-intentioned people who wish to volunteer in hospitals. Nevertheless, having large numbers of volunteers working in hospital settings involves risks and the Savile case has clearly highlighted the need to ensure reasonable precautions to protect vulnerable people from those who might seek to do them harm under the guise of volunteering. Given what we found about the variability of proper processes for the management of NHS volunteer schemes, we recommend that all NHS trusts review their arrangements in relation to the management of volunteers, including their training, to ensure they are fit for purpose and offer appropriate risk management.

11.42 Staff at NCVO referred us to the accreditation scheme 'Investing in Volunteers' (iV), which is overseen by the UK Volunteering Forum and managed by NCVO. It sets a quality standard for all organisations involving volunteers in their work. The accreditation process involves drawing up a development plan and assessment visits. NCVO told us that one hospital found that the framework for managing volunteers devised as part of the hospital's accreditation had resulted in it attracting better volunteers with increased skills who were better able to contribute to the work of the hospital. Hospital trusts may wish to consider as part of their review of their voluntary services whether to apply for accreditation under the iV scheme.

Recommendation

R2 All NHS trusts should review their voluntary services arrangements and ensure that:

- they are fit for purpose;
- volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
- all voluntary services managers have development opportunities and are properly supported.

11.43 NAVSM was set up by voluntary services managers in the NHS to provide themselves with peer support, learning and networking opportunities. It has about 140 members, on whose time and goodwill it relies. Our discussions with voluntary services managers and others suggested a need for a properly resourced forum for voluntary services managers, in particular to enable the dissemination of best practice. We recommend that the Department of Health and NHS England should facilitate this.

Recommendation

R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support, learning opportunities and disseminate best practice.

12. Safeguarding

12.1 For the purposes of our work we have taken safeguarding to mean actions required to protect people from harm and abuse, particularly sexual abuse.⁴²

12.2 The NHS investigations into Savile found that he had had unsupervised access to NHS hospitals and that staff had failed to challenge his behaviour. This gave him opportunities to abuse patients and others. This has led us to consider the robustness of safeguarding measures in NHS hospitals today. This section of our report sets out what we found out about awareness of safeguarding and the present systems and resources in NHS hospitals to respond to safeguarding needs; we then set out our observations on how those systems and resources need to function in order to safeguard people as effectively as possible. We conclude this section by commenting on a number of specific matters of concern in relation to safeguarding which require further consideration and action.

Awareness of safeguarding issues

The development of social attitudes, law and guidance

12.3 Social attitudes and public policy in relation to the protection of children and young people have changed and developed significantly since the time that Savile first started volunteering in NHS hospitals. In the 1960s child protection legislation and arrangements were principally focused on local authority responsibilities for children in care and in enabling children convicted of criminal offences to be subject to care orders.

12.4 The 1974 report into the abuse and death of Maria Colwell at the hands of her stepfather gave the issue of child abuse wide public exposure. It led to measures aimed at better coordination of child protection services, including the establishment of area child protection committees, inter-agency child protection conferences on specific cases and child protection registers to identify children at risk.

⁴² We acknowledge however that the term can have a wider meaning and implications for professionals engaged in caring for children. See the definition in the introduction to *Working Together to Safeguard Children; A guide to inter-agency working to safeguard and promote the welfare of children*. HM Government (March 2013). p.2

12.5 In 1986 the charity ChildLine was set up after a significant public response to a helpline and survey related to a BBC 'That's Life' programme on the subject of child abuse. The following year, what became known as the Cleveland sexual abuse scandal occurred, in which two paediatricians in Middlesbrough diagnosed more than 120 cases of sexual abuse leading to the children in question being removed from their families. Most of the claims of abuse were eventually dismissed and the children returned to their homes, but this case, together with the founding of ChildLine, prompted widespread public and media discussion of issues previously not openly talked about. It led to an acknowledgement of the need for a greater understanding among clinicians and other professionals about child sexual abuse.

12.6 The Children Act 1989, which came into force in 1991, forms the basis of the current child protection system. It introduced the principle that the child's welfare is paramount in any decision that affects them. It sets out in detail what local authorities and courts should do to protect the welfare of children.

12.7 The government published the Green Paper *Every Child Matters* (HM Government, 2003) after Lord Laming's inquiry into the death of Victoria Climbié. Its proposals led to the Children Act 2004. It creates a Children's Commissioner for England. It places a statutory duty on local authorities and their partners (including police, health services providers and the youth justice system) to safeguard and promote the welfare of children and it requires them to cooperate in improving the well-being of children, including protecting them from harm and neglect. It requires local authorities to establish local safeguarding children boards (replacing area child protection committees) to oversee the safeguarding of children and requires local authorities to produce annual child and young persons plans and to appoint directors of children's services.

12.8 In England, statutory guidance to help professionals identify children at risk and promote inter-agency cooperation was introduced in 1991. The current version of that guidance is *Working Together to Safeguard Children* (HM Government, March 2013). It provides guidance on how agencies should work together to safeguard children, sets out roles and responsibilities of individual professionals who come into contact with children and describes child protection processes. It emphasises the shared responsibility of all those in contact with children to protect them from harm. It recognises the risk to children from employees, including volunteers, and the need to develop safeguards to maintain a safe environment.

12.9 In addition to laws and guidance setting out the duties of public bodies to protect children, a number of laws have been introduced in recent years which allow for the monitoring of people who pose a risk to others, creating offences with which they can be charged and stopping them from working with children. Among these is the Sexual Offenders Act 1997, which requires sex offenders to notify police of their names and addresses and any subsequent changes (the sex offenders register). The Sexual Offences Act 2003 updates legislation relating to offences against children. It includes the offences of grooming, abuse of positions of trust, and trafficking and covers sexual offences committed by UK citizens abroad.

12.10 The Bichard inquiry into the Soham murders led to the introduction of the Safeguarding Vulnerable Groups Act 2006, which established a new centralised vetting and barring scheme for people working with children and vulnerable adults. The Act was amended by the Protection of Freedoms Act 2012, which replaced the vetting and barring scheme with a scaled-back disclosure and barring service.

12.11 In 2003 the Department of Health published *Getting the right start: the National Service Framework for Children, Standard for Hospital Services*. This sets standards for the design and delivery of services for children, the safety and protection of children in hospital and the quality of care. It sets an expectation that hospitals will place children who are inpatients on children's or adolescent wards rather than with adult patients.

12.12 England and Wales do not presently have legislation in force aimed specifically at safeguarding adults vulnerable to abuse. However, the guidance *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (Home Office and Department of Health, March 2000) sets out a code of practice for protecting adults vulnerable to abuse. It explains how commissioners and providers of health and social care services and other statutory authorities should work together to produce and implement local policies and procedures. In response, local authorities have established local safeguarding adults' boards with procedures similar to those of local safeguarding children boards. And English local authorities will have a statutory duty to establish Safeguarding Adults Boards as from April 2015⁴³.

⁴³ Under Care Act 2014 section 43.

Awareness and attitudes within NHS hospitals

12.13 The evidence we gathered indicates that in keeping with the wider societal developments we refer to, awareness among NHS staff of the issue of safeguarding and of their obligations to protect patients, especially children and young people, from abuse, harm, and inappropriate behaviour has increased markedly in recent years. A number of interviewees referred to the role that the recent scandals of the treatment of patients at Winterbourne View, the findings from the Francis inquiry into Mid Staffordshire NHS Foundation Trust⁴⁴ and the Savile case itself had had in heightening awareness of safeguarding. The director of nursing and clinical governance at Royal Brompton and Harefield NHS Foundation Trust wrote in her response to our call for evidence:

“The higher profile of safeguarding matters in society and in the media as well as the NHS has led to reports and investigations of more concerns than in the past and I believe that staff in particular are clearer about their responsibilities for this aspect of care of patients, visitors and colleagues”.

12.14 The medical director at Ipswich Hospital NHS Trust told us:

“The Savile report [sic] and the Francis report have completely changed the culture...There is a much better understanding of people raising concerns, whistle blowing, and people are now much more professionally aware that, if they are practising in an area where they feel the safety or quality of care of patients is being put at risk they are openly coming forward and saying so.”

12.15 The named nurse for safeguarding children at the same hospital told us that the Savile case and the Francis report had *“opened people’s eyes, myself included”*.

12.16 And the named nurse for safeguarding children at Medway NHS Foundation Trust told us:

“When I first started 12 years ago in this role, I know from the nursing point of view that the nurses were very timid and reluctant if they had concerns about what they should do. I feel now looking at the training and auditing work we have

⁴⁴ Robert Francis QC (February 2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*.

done...it has moved in leaps and bounds. I have contact with staff on a day-to-day basis who say "I have these concerns, what should I do?" "

12.17 The awareness of safeguarding among hospital staff and the public at large will no doubt have been greatly increased as a result of the recent report into the shocking child abuse over many years in Rotherham.⁴⁵

12.18 All the hospitals we visited, and most of those who responded to the call for evidence, told us that all their staff, both clinical and non-clinical, received mandatory induction training that included safeguarding, with higher levels of safeguarding training being mandatory for all clinical staff working with children and vulnerable adults. We met with many ward staff during our visits. By and large, our conversations with them supported what managers had told us about improvements in training and increased staff awareness in relation to safeguarding.

12.19 Nevertheless we received evidence that not all hospitals deliver safeguarding training of a high quality. For instance, a senior manager at a large inner city hospital trust told us that safeguarding training for security staff amounted to no more than receiving a safeguarding leaflet along with their first pay slip. At our discussion event which considered how hospitals should manage the risks of abuse, Dr Peter Green, consultant forensic physician and child safeguarding lead for NHS Wandsworth and St George's Healthcare NHS Trust told us of his concerns about the effectiveness of safeguarding training. He said organisations need to test whether those who receive safeguarding training in fact learn from it. He said:

"Training is completely pointless if you don't assess whether anyone has learnt anything. We have done three surveys in my Trust where we had a gang of students on a particular day and then went and stopped people in the corridor and gave them a questionnaire. We analysed the results. We then learnt from that how...ineffective our training was being. We have changed the structure and modified it. It is no good going to training, ticking the box. What really matters in terms of outcomes is have they learnt something? You must test that. That is a really important message to do with training."

⁴⁵ Professor Alexis Jay OBE (2014) *Independent Inquiry into Child Sexual Exploitation in Rotherham (1997-2013)*.

12.20 Furthermore, while most of our interviewees agreed that safeguarding needs constant revisiting and reinforcement, we learnt of hospitals that, contrary to the requirements of the royal colleges and other healthcare professional bodies,⁴⁶ did not ensure that all their staff had their safeguarding training updated on a regular basis. The responses to our call for evidence also raised questions about attendance rates at update training sessions at some hospitals.

12.21 Dominique Black, regulatory policy manager at the Care Quality Commission (CQC), who has an operational background as an inspector with CQC warned about awareness of safeguarding matters. She told us her experience suggested that while staff might be aware of the issues raised by the recent exposure of abuses, they may not necessarily recognise the implications of these issues for themselves and their own organisations.

Safeguarding resources

12.22 We asked each of the hospitals we visited to describe their safeguarding arrangements. The largest, best-resourced team we encountered was at Guy's and St Thomas' NHS Foundation Trust in London. This is perhaps unsurprising given the size and nature of the population that the trust serves and that in recent years the trust has taken on the management of community services for the London boroughs of Southwark and Lambeth. However, we were impressed not merely by the size of the team but also by what we learnt about its high profile in the hospital, how it operated and its effectiveness in supporting staff and in handling a large safeguarding caseload.

12.23 The chief nurse and director of patient experience who has responsibility for safeguarding in the trust told us that in 2005 the safeguarding team amounted to one named nurse in child protection, one named midwife and no one with responsibility for vulnerable adults. In August 2014 the team that covered both acute and community care had increased to nine whole-time equivalent staff (wte) responsible for safeguarding vulnerable adults (including those with dementia and learning disabilities) and sixteen wte responsible for child safeguarding. The team worked in an integrated way and covered for each other. All trust staff, including support staff and non-executive directors, undertook

⁴⁶ See the royal colleges and professional bodies' Intercollegiate Document (March 2014) *Safeguarding Children and Young People: roles and competencies for health care staff*. London: Royal College of Paediatrics and Child Health.

a one-and-a-half-day induction programme that included safeguarding. Most clinical staff were required to undertake a higher level (level 2) safeguarding training and those caring for children undertook further training (level 3). Refresher training every three years was mandatory. Members of the safeguarding team described how they made links with other parts of the organisation, including the complaints and security teams, and they described how all parts of the organisation made referrals to them and sought their advice. The adult safeguarding lead told us:

"When I started we would get referrals from A&E, admission wards and Elderly Care and I would not get referrals from anywhere else. Whereas now I have referrals from every single ward and even outpatient areas, so safeguarding is embedded within the trust."

12.24 We were impressed by the contribution of the security staff at Guy's and St Thomas' to safeguarding at the trust. At one of the trust's sites security staff were recognised as part of the safeguarding team and attended its team meetings. Security staff contributed as a matter of course to the process of drafting policies relevant to safeguarding. Security staff were managed with a view to making them as approachable as possible and making a contribution to safeguarding beyond merely physical security measures. For example, the trust deliberately employed female as well as male security staff and security staff wore an informal uniform; unlike at most other London hospitals, they did not wear stab vests. Amanda Millard, group director of operations and Jayne King, head of security, explained that these measures were designed to make security management less confrontational and to offer reassurance to the public. Amanda Millard explained:

"in terms of conflict resolution, treating violence with violence and teaching staff to be violent can only be bad.."

12.25 And Jayne King told us:

"it's about the message it sends. If we are trying to work with patients and saying we are providing a safer environment and then you have security staff walking around in combat trousers and stab vests, what does that say to you?"

12.26 Jayne King also told us that as a result of the security staff's profile in the organisation other staff and members of the public had raised concerns with them, including safeguarding issues. She said:

"They will call us about things that may be clinical, something they are not happy about and they don't want to take it through their line management route, because they know we have contacts, so we will speak to safeguarding...So we are used as another avenue for people to be able to talk about things..."

12.27 We believe that Guy's and St Thomas' offers a model for how other groups of hospital staff can contribute to and enhance the work of safeguarding teams.

12.28 One district general hospital we visited was at the other end of the scale from Guy's and St Thomas' for safeguarding resources. When we visited in May 2013, the hospital had a named midwife and a named doctor for child safeguarding, both practising clinicians, but day-to-day management of child safeguarding matters, including staff support and training, rested with the full-time named nurse for safeguarding children. In the months before our visit she had begun to be supported part-time by another nurse. The named nurse for safeguarding children conceded that she found herself stretched by the demands of her role, and there was no cover for her role during her absence. When we visited, the hospital had a nurse lead for adult safeguarding. It had only recently appointed a lead doctor for adult safeguarding.

12.29 This hospital also told us that it had an internal operational safeguarding group that considered and formulated safeguarding policies and practices. Its members were nursing staff, including the director of nursing, the named doctor for safeguarding children, the named midwife, the head of midwifery and a human resources representative. The chief nurse told us they had worked jointly with the trust's HR team on a policy to identify staff with personal problems that might make them unsuitable to work in the hospital.

12.30 Another district general hospital had a number of named doctors and a named midwife for child safeguarding but day-to-day management and coordination of child safeguarding matters rested with the full-time named nurse for child safeguarding. She admitted that she sometimes felt overstretched by her workload. The hospital had only one full-time employee, the safeguarding vulnerable adults' coordinator, with day-to-day

responsibility for adult safeguarding. The chief nurse at the hospital told us: *“One person probably isn’t enough adult safeguarding given the complexity of the patients that we now look after”*.

12.31 Although this hospital had limited full-time staff resources devoted exclusively to safeguarding the safeguarding staff described how they planned to devolve learning and responsibility across the organisation to ensure greater resilience in their safeguarding work. In particular, they told us they had appointed a clinical nurse lead for adult safeguarding in each directorate, the aim being *“to improve ownership within the Directorates around safeguarding, and to expand the pool of knowledge”*. The safeguarding vulnerable adults coordinator told us she planned to institute regular meetings of the clinical nurse leads and to increase the level of their adult safeguarding training. A similar network of clinical nurse leads for child safeguarding had been in place at the hospital for some years.

12.32 Staff at a children’s hospital we visited told us they had two full-time and one part-time member of staff, one of them the named nurse for child protection, with day-to-day responsibility for safeguarding. They too had appointed a member of staff in each ward or department with local responsibility for safeguarding in their service area. This group of staff met together regularly. The chief nurse at the hospital explained the thinking behind their arrangements:

“Safeguarding is everybody’s responsibility so there’s no good having a massive team because potentially people feel they can absolve themselves of their responsibility. So [the named nurse] set up link workers from all wards and departments and goes down to A&E and key areas. Working with the A&E staff, and working in different departments to get people to “get it” has been the way that we’ve tried to work”.

12.33 Our investigations showed that numbers of dedicated safeguarding staff varied widely in different NHS hospitals and in some cases staff resources were stretched. However, we saw that organisations, especially those with limited dedicated safeguarding teams, can increase awareness of safeguarding among staff and their effectiveness in this area by appointing individuals in directorates, wards and specialist teams as safeguarding leads or champions. Moreover, as we learnt at Guy’s and St Thomas’ and elsewhere, other

staff groups, such as security and HR teams, can make a valuable contribution to the development of safeguarding related policies and other safeguarding arrangements.

12.34 As we show in the next section, the numbers of staff in dedicated safeguarding roles is not the only key to effective safeguarding. It is however essential that all staff should be trained to identify safeguarding issues and should be able at all times to access specialist support and advice if necessary.

12.35 We recommend that all NHS hospital trusts review their safeguarding resources, structures and processes (including their training programmes) to ensure that their safeguarding arrangements are as effective as possible.

Effective safeguarding

12.36 A number of recent reports of investigations and studies have considered, some extensively, the organisational, process and behavioural factors associated with failings in patient care and safeguarding⁴⁷. We will not try to restate them all here, nor will we repeat what the separate NHS Savile investigation reports say about the circumstances and failings in each organisation that allowed Savile the opportunity to commit his abuses. Our work gave us the opportunity however, taking account of the findings of all these reports, to reflect on what makes for an effective hospital safeguarding system from the particular perspective of seeking to prevent a recurrence of events similar to the Savile case. In this section we set out what we believe are the most important behavioural and operational features or requirements of such a system. Our intention is to offer guidance to NHS hospital trusts for use in assessing the effectiveness of their own safeguarding arrangements.

⁴⁷ See: Robert Francis QC (February 2010) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Lord Laming (2009), *The Protection of Children in England: A Progress Report*. Department of Health (June 2013), *Transforming Care: a national response to Winterbourne View Hospital*. Professor Sir Bruce Keogh KBE (July 2013), *Review into the quality of care and treatment provided by 14 hospitals in England*.

Leadership that promotes the right culture

12.37 We spoke to many people with significant experience of dealing with safeguarding, including sexual abuse. Most emphasised the fact that keeping people safe requires organisations to have values and a culture that engenders awareness of and active responses to safeguarding issues. Jane Held, a former director of social services who now chairs two local safeguarding boards, told us that while effective safeguarding requires adequate resources, it is *“more about culture and behaviours”*. She and others were keen to point out that it does not require more bureaucracy.

12.38 The reports of the investigations into Savile’s abuses at Stoke Mandeville Hospital, Leeds General Infirmary and Broadmoor make clear how the social culture of the age, as well as the dispersed and hierarchical management arrangements in hospitals, discouraged the reporting of his abuses and meant that concerns or complaints about him were not properly dealt with.

12.39 The Stoke Mandeville investigation team concludes:

“Stoke Mandeville Hospital had complaints policies and procedures in place during the 1970s and 1980s when the ten victim reports were made. However, the management infrastructure was disorganised and weak, which led to a silo-based management of the complaints process. This had the effect of preventing complaints from being resolved appropriately or coming to the attention of the senior administrative tier.”⁴⁸

12.40 The Leeds investigation team comes to similar conclusions:

“We have heard repeatedly how the culture of the Infirmary during the 1960s to 1980s was formal, hierarchical and structured in rigid professional lines of accountability. Generally, the staff who witnessed, or who heard disclosures from staff about Savile, were closer to the “front line” of the clinical areas, and remote from the management structure. So if anything was spoken about Savile more widely, it was in the form of gossip, nuance and rumour, and not formally actioned...From what was known about his disruption to clinical areas, and his

⁴⁸ Stoke Mandeville investigation report, para. 13.108

behaviour as a sexual nuisance to female staff, it is hard to accept that this was not seen as potentially harmful, reported to more senior staff, or challenged more rigorously. The culture of the organisation at the time and the attitudes to what was deemed appropriate to report to more senior staff will have had a major influence on behaviours. We heard from both patient and staff victims a strongly held belief that they would not be taken seriously if they reported their encounters with Savile, and that even if they did, and were believed, that no action would be taken because of their perception that senior people in the Infirmary were of the opinion that he did so much good for the organisation and that this should not be compromised.”⁴⁹

12.41 The findings of the Savile investigation teams, our own interviewees and research literature⁵⁰ make clear that ensuring concerns about sexual abuse are identified and properly managed demands that boards and individual leaders of organisations are clear about and communicate their intention to take safeguarding seriously; it demands mechanisms that allow people to feel able to raise their issues and concerns; and it demands demonstrating that those issues and concerns are dealt with appropriately. It has also been made clear to us that individual members of staff, indeed all individuals, need to be made aware of their obligation to raise matters of concern about abuse and not turn a blind eye. Hilary McCallion, the former director of nursing and education at South London and Maudsley Foundation Trust and formerly that organisation’s board lead for safeguarding children, told us how she described to staff the obligations they were under:

“It was about citizenship that was the way I approached it, as a citizen of this country, you have a responsibility, a duty. It’s nothing to do with work, this is about your responsibility and duty as a citizen of this country”.

12.42 Donald Findlater, director of research and development at the Lucy Faithfull Foundation told us:

“It is about how you create that climate, so everyone knows that “part of my job is safeguarding, this is a place where children or vulnerable adults should expect

⁴⁹ Leeds investigation report, p.163

⁵⁰ See for example, Erooga and other (2012) *Towards Safer Organisations II: Using the perspectives of convicted sex offenders to inform organisational safeguarding of children*.

to be well treated, and if I notice that they are not being I have an obligation to say something and do something about that”.

12.43 We wanted to understand more about the culture of organisations that successfully create a safety conscious environment, so we interviewed the director of people, legal and government and industry affairs at British Airways and the vice-president of Shell UK with responsibility for human resources. They told us that the message of safety was paramount in all their organisational activities - a message constantly reinforced. Shell told us the safety culture was a priority set and demonstrated from the top and thus seen as a priority throughout the organisation. The culture was reinforced by an appraisal system that focused not just on performance but also on how a member of staff had adhered to the behaviours and values of the organisation. In addition, the company routinely investigates “near miss” events where its own employees have not been at fault but which have had safety implications.

12.44 Overall our visits to NHS hospitals suggested that they recognised the need to develop their cultures and values in a way that encouraged the openness, leadership and support that staff needed to deliver effective safeguarding. Some organisations had evidently made progress in developing this culture and values but others still had work to do. In many of the organisations we visited it was made clear to us that at board level safeguarding is not managed as a shared responsibility. One board director told us “...*there is a strong message from our board [about safeguarding], to be honest though it is still through me, it is still really only owned by one executive*”. We believe this silo-based approach may undermine the development of an organisation-wide understanding and promotion of safeguarding.

Openness and listening when people, including children, raise concerns

12.45 Many of our interviewees spoke of the need for organisations to train and encourage staff to listen and understand when people raise matters that suggest a risk of harm or abuse and to recognise such risks for themselves. The director of workforce at Guy’s and St Thomas’ NHS Foundation Trust told us that the Mid Staffordshire and Savile cases were “*an opportunity to remind individuals about how important it is to have open conversations and to listen when people raise concerns.*”

12.46 The investigations at Leeds General Infirmary and at Stoke Mandeville and Broadmoor Hospitals revealed that a number of Savile's victims told hospital staff at the time what had happened to them. In most cases, the staff in question brushed off or refused to believe what they had been told or simply failed to respond to it. None of the reports of particular abuses made to staff were dealt with as a matter of serious concern and escalated to senior managers. The same appears to have been the case with Savile's more general, inappropriate and disruptive behaviour. The Leeds investigation team identified the culture required to ensure that matters were reported and dealt with in the following way:

*"one that welcomes and nurtures staff and patients to feel empowered to raise concerns"*⁵¹

*"Those who receive such reports of concerns need to be confident to know what to do with the disclosures, and then act swiftly and responsibly, driven by a guiding principle to safeguard the welfare of patients and staff. Repeatedly, in the accounts from victims - staff and patients - this was not the case."*⁵²

12.47 The Savile case illustrates how important it is in identifying abuse that staff do not dismiss what they are told. Interviewees with experience of child sex abuse cases pointed out that staff should especially guard against discounting what children tell them. One experienced children's nurse explained to us *"It would be very rare for a child to make an allegation which isn't true around sexual abuse because they wouldn't know what it was."*⁵³ The Stoke Mandeville Investigation report says:

*"It is an important fact that children often do not have the language to explain the details of a sexual assault; at least three victims who reported what happened to them were non-specific about what Savile actually did."*⁵⁴

12.48 Further, the Savile investigations showed that all hospital staff, including managers, must keep their minds open and be vigilant about the potential for harm and abuse in the hospital. The Leeds investigation report makes the point as follows:

⁵¹ Leeds investigation report, p.164

⁵² *Ibid*, p.165

⁵³ Debbie Parker, deputy chief nurse, Guy's and St. Thomas's NHS Foundation Trust

⁵⁴ Stoke Mandeville investigation report, para. 13.89

“We found absolutely no evidence to suggest that those in leadership positions we interviewed knew Savile was sexually assaulting patients and staff. However, we did hear that on occasions they found his behaviour inappropriate for a hospital setting. This discomfort felt amongst some staff at the top of the organisation did not prompt them to appreciate the potential impact Savile may have had on junior members of staff or even on patients for whom they were responsible.”⁵⁵

“It appeared that they did not connect their own feelings about him as an individual with any potential wider risk to the Infirmary, its staff or patients.”⁵⁶

Approachable and informed senior staff

12.49 Interviewees told us that having senior staff who are visible and approachable is key to getting staff to voice their concerns or suspicions about safeguarding. They must make it possible for junior staff to share their concerns. Senior staff also told us that it is only when they are on wards that they really hear and understand what is happening in their organisations and pick up valuable information about matters that might be amiss.

12.50 The Stoke Mandeville and Leeds investigation reports reveal that the disconnection of senior managers from the ‘frontline’ of their organisations meant that they did not know about widespread rumours and concerns about Savile’s general behaviour or of the individual complaints made by victims of his abuse. Had they been aware of these matters, they could have acted to bring Savile’s presence in their hospitals to an end. The Stoke Mandeville report says:

“The Investigation concludes that during the 1970s Savile’s reputation as a sex pest and poorly performing porter at Stoke Mandeville Hospital was an open secret amongst junior staff and some middle managers. The Investigation also concludes that complaints were probably filtered out before they reached the attention of senior administrators at the Hospital. Whilst none of the witnesses we interviewed claimed to have had any knowledge of Savile sexually abusing patients or visitors, most of the people that were interviewed acknowledged he was “creepy” and “a lecher”. The evidence shows that the culture, systems and practice within Stoke

⁵⁵ Leeds investigation report, p.173

⁵⁶ *Ibid*, p.174

*Mandeville Hospital during this period ensured that complaints, concerns and grievances were managed in a 'closed loop' which prevented an open and transparent approach being taken, and that Savile was given a high degree of leeway regarding his performance and conduct due to his celebrity status.*⁵⁷

12.51 The Leeds Investigation report says:

*"We have heard repeatedly how the culture of the Infirmary during the 1960s to 1980s was formal, hierarchical and structured in rigid professional lines of accountability. Generally the staff who witnessed, or heard disclosures from staff about Savile were closer to the "front line" of the clinical areas, and remote from the management structure. So, if anything was spoken about Savile more widely, it was in the form of gossip, nuance and rumour, and not formally actioned".*⁵⁸

*"Many warning signs given out by Savile were not seen, and even if they were, it would appear that the systems in the hospital made it almost impossible for concerns to be raised to a level where action could take place or the bigger picture could be seen."*⁵⁹

12.52 We heard of good examples of senior managers spending time on wards making themselves visible and approachable by staff and picking up on issues of concern. Northumberland, Tyne and Wear NHS Foundation Trust told us about their 'observational shifts' programme, under which a number of the senior executive team spent a shift working on a ward or in a specialist service each week. One member of that team told us that she discovered the trust's arrangements for medical tests were inappropriate for their rehabilitation patients only as a result of her placement on a rehabilitation ward.

12.53 The chief nurse at Guy's and St Thomas' NHS Foundation Trust also described how for the past nine years she and the rest of the senior nursing team had undertaken clinical work on wards every Friday. She said this had given staff at all levels the confidence to raise concerns with them directly either face to face or in writing.

⁵⁷ Stoke Mandeville investigation report, para. 11.117

⁵⁸ Leeds investigation report, p.163

⁵⁹ *Ibid*, p.164

Training and communication

12.54 Training staff and communicating with them about safeguarding are essential to ensuring that they are properly aware of it and to encouraging them to raise concerns. Good communication between staff is also necessary to ensure that they put together a true and complete picture of any safeguarding problems.

12.55 Organisations told us of the different ways they communicated safeguarding messages to staff. One had put a leaflet in all payslips, assuring staff about how they would be supported if they raised concerns; another used regular staff forums to promote awareness; most organisations told us that safeguarding had often featured in their regular newsletters to staff; and one organisation had a dedicated quarterly safeguarding newsletter. Interviewees spoke of the need for constant reinforcement of the messages about safeguarding. The interim chief executive at Birmingham Children's Hospital NHS Foundation Trust told us "*We continue to do work with our staff and I think this is just a never-ending piece of work around how they raise concerns.*"

12.56 The participants in our discussion event that considered how organisations ought to manage the risks of abuse also stressed to us the need to reinforce safeguarding messages through training and communication with staff. They commended the Scout Association's efforts to ensure safeguarding awareness through the use of a pocket-size card (known as the yellow card). It sets out the association's code of behaviour, based on its child protection policy, the duty to report breaches of the code of behaviour and information about how to report concerns. All adults involved in scouting carry a copy. The participants in the discussion event commended the yellow card for offering a constant reminder and reinforcement of the safeguarding message. Dr Peter Green said:

"Some of this stuff needs to be like fire alarm training...safeguarding training should be something you do every week, you repeat it every week so everybody knows it inside out...so we all know exactly what the rules are."

12.57 Participants in the discussion event also approved of the way the yellow card makes clear the boundaries of acceptable behaviour and makes clear that inappropriate behaviours will result in disciplinary action. They told us that all organisations need to be explicit with their staff about what behaviours are and are not appropriate and are or are not to be tolerated. They said many safeguarding incidents occurred when there were

'grey areas'. Donald Findlater urged that all NHS organisations and the NHS as a whole ought to consider introducing a code of behaviour along the lines of that produced for the education sector, *Guidance for safer working practice for adults who work with children and young people in education settings*.⁶⁰

12.58 We set out above what NHS hospitals themselves told us about the provision of safeguarding training for staff and volunteers, including the fact that some hospitals do not ensure that all staff and volunteers update their safeguarding training on a regular basis. The report on research undertaken in 2012 into the behaviours and circumstances leading to referrals to the Independent Safeguarding Authority⁶¹ of people suspected of posing a risk of harm to children and vulnerable adults indicates that in the sample of cases examined, staff appeared on the whole to have had appropriate qualifications and training. But the report authors also observe "*what did not emerge...was evidence of the currency or regularity of training. This suggests a potential need for employers to ensure ongoing refresher training where appropriate, as developments occur in the sector or working practices emerge. One example of a potential gap was evident in children's cases in respect of online communication and the use of social media, which was a common feature of grooming behaviour and sexual abuse cases.*"⁶²

12.59 Given the importance of ensuring constant vigilance among staff in relation to safeguarding and the potential for new risks of harm to emerge as identified in the ISA research, we believe that all hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at least every three years.

Recommendation

R4 All NHS hospital trusts should ensure that all staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

⁶⁰ Department for Children, Schools and Families (March 2009)

⁶¹ The forerunner of the Disclosure and Barring Service

⁶² McKenna, K. and Day, L. (March 2012) *Safeguarding in the Workplace: What are the lessons to be learned from cases referred to the Independent Safeguarding Authority?* p.54

Responsiveness and feedback to staff

12.60 If hospital staff are to be encouraged to raise concerns about safeguarding, organisations must demonstrate that those concerns will be taken seriously and that the organisation will respond appropriately. The Leeds investigation found that staff who had observed Savile's behaviour and thought it was inappropriate felt inhibited from taking action or reporting their concerns in part because they thought senior managers would not take them seriously or would not act on their concerns. Managers at Birmingham Children's Hospital NHS Foundation Trust told us about a recent safeguarding issue that had been dealt with promptly and decisively and how it had been widely communicated to staff. Staff told us how important this was in promoting and reinforcing the safeguarding agenda. One said: *"It is those kinds of things, when you see that response, you know that they mean what they say and that if you were ever in such a situation, you have that support"*.

12.61 And the chief nurse at Guy's and St Thomas' NHS Foundation Trust told us *"If you raise something, you raise a matter of concern and it is not acknowledged and then nobody feeds back then you will not do it again. There is no incentive to do it again..."*

Effective safeguarding: conclusion

12.62 The operational and behavioural features of effective safeguarding we have set out here are hardly novel or revolutionary. They may seem obvious. But the lack of these features in the hospitals with which Savile had a relationship clearly contributed to his acting as he did. NHS hospital trusts need to ask themselves regularly whether their own arrangements are characterised by the specific features of effective safeguarding which we have identified.

Recommendation

- R5 All NHS hospital trusts should undertake regular reviews of:
- their safeguarding resources, structures and processes (including their training programmes); and

- the behaviours and responsiveness of management and staff in relation to safeguarding issues

to ensure that their arrangements are robust and operate as effectively as possible.

Specific safeguarding issues

12.63 In this section we comment on weaknesses we identified in relation to the management of safeguarding in NHS hospitals. We believe these matters require further consideration and action by the relevant bodies referred to in our recommendations.

DBS checking

12.64 We looked at the current legislative framework governing record checks for those who work or volunteer in NHS hospitals. Our visits to hospitals and the responses to the call for evidence informed us about the policies and arrangements NHS hospitals have in place to undertake such checks.

12.65 The Safeguarding Vulnerable Groups Act 2006 as amended by the Protection of Freedoms Act 2012 (SGVA) sets out the activities and work that are ‘regulated activity’ and which a person on the barred lists maintained by the Disclosure and Barring Service (DBS) must not do. An organisation engaging staff and volunteers in ‘regulated activity’ can access a barred list check by requiring those staff and volunteers to undertake an enhanced DBS check (previously known as a CRB check) together with a barred list check.

12.66 Subject to a small number of exceptions, it is unlawful for any employer to require an enhanced DBS check with barred list information for any position other than one that is ‘regulated activity’ as defined by SVGA.⁶³

⁶³ An organisation engaging staff and volunteers not in ‘regulated activity’ can only require standard or enhanced DBS checks without a barred list check if those staff or volunteers are eligible because of their activities. To be eligible for an enhanced check the position must be specified in the Exceptions Order to the Rehabilitation of Offenders Act 1974 and regulations made under the Police Act 1997. The relevant activities encompass and are wider than those defined as “regulated activity” and include, for example, work or volunteering in children’s hospitals, the regular care of adults or any form of treatment or therapy.

12.67 The DBS maintains a list of people barred from engaging in 'regulated activity' with children (the children's barred list) and a list of people barred from engaging in 'regulated activity' with adults, (the adults' barred list). A person is placed on a barred list either following a caution or conviction for specified offences, in which case they are barred automatically, or as a result of the DBS exercising its discretion to bar a person after referral and information supplied by employers, providers of 'regulated activity' or professional regulatory bodies.

12.68 We found limitations and anomalies in the present definition of 'regulated activity', and therefore of those subject to barring list checks, which gave us cause for concern.

12.69 Amendments made to SGVA by Part 5 of the Protection of Freedoms Act 2012, which came into force on 10 September 2012, introduced new and more limited definitions of the 'regulated activity' which a person who has been barred must not undertake.⁶⁴

12.70 The new definitions applicable in England and Wales and set out in Schedule 4 to SVGA are perplexingly intricate. Anyone wishing to consider them in full should refer to that schedule and to the Department of Health and Department for Education's guidance notes on regulated activity⁶⁵. For the purposes of this narrative they can be summarised as follows.

12.71 In relation to adults, the new definition of 'regulated activity' is based on six identified categories of activities. A person needs to carry out these activities only once for it to be 'regulated activity'. The categories are:

- healthcare provided by or under the supervision of a healthcare professional;
- providing personal care;

⁶⁴ It is an offence for any organisation knowingly to appoint or continue to allow an individual who is barred from working with children or vulnerable adults to engage in a 'regulated activity' with that group. And an individual is committing an offence if they engage in a 'regulated activity' when barred from doing so.

⁶⁵ <http://www.dh.gov.uk/health/2012/08/new-disclosure-and-barring-services-definition-of-regulated-activity/>;
<http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/a00209802/disclosure-barring>

- assistance with general household matters (including managing cash, paying bills, doing shopping);
- assistance with the conduct of a person's own affairs (e.g. under an enduring power of attorney); and
- conveying someone for the purposes of their receiving healthcare or relevant personal care or relevant social work.

12.72 In relation to children, the new definition, in outline, comprises: a) undertaking on an unsupervised basis the activities of teaching, training, instructing, caring for or supervising children or b) working in a limited range of establishments which includes schools, children's homes but not hospitals. These two categories of activity are 'regulated activity' only if carried out by the same person frequently, defined as once a week or more often, or on four or more days in a 30-day period or overnight. In addition, in relation to children 'regulated activity' includes healthcare provided by or under the supervision of a healthcare professional, relevant personal care and registered child minding and foster care.

12.73 In the context of NHS hospital settings, what amounts to 'regulated activity' in relation to adults differs significantly from that relating to children. With adults, only those staff or volunteers whose work involves direct hands-on or close contact with adult patients can be required to undergo a barring list check, (this applies whether they undertake the activity in question once or more frequently and whether or not they are supervised in it). With respect to children a wider group of staff and volunteers, including those with less intimate contact can be required to undergo a barring list check but only if they undertake such work frequently and unsupervised.

12.74 The arrangements we describe above under which organisations can require barring list checks for staff and volunteers replace the wider arrangements and definition of 'regulated activity' provided for in the Vetting and Barring Scheme (VBS) set up under the Safeguarding Vulnerable Groups Act 2006 after the Richard Inquiry.

12.75 Under its *Programme for Government* the present coalition government committed to reviewing and scaling back the VBS. The arguments for scaling back record checking and reducing the number of people who could be subject to barring list checks are set out in the report and recommendations of the *Vetting and Barring Scheme Remodelling Review* (February 2011), a review undertaken jointly by the Department for Education, the

Department of Health and the Home Office⁶⁶. Among those arguments is the need to tackle the perception that the VBS “went too far”. As the executive summary to the report states: *“the [VBS] would have required 9.3 million people to register with, and be monitored by the scheme and shifted the responsibility for ensuring safe recruitment to move away from the employer towards the state. It would also have had the counter-productive effect of deterring well-meaning adults from working with and improving the lives of children and vulnerable adults.”* The executive summary goes on to say that in placing the emphasis on the state, the VBS *“encourages risk aversion rather than responsible behaviour. It is the effective management of risk rather than aversion of risk which is most likely to protect vulnerable people.”* In the introduction to the report on page 6 the authors expand on the idea of the VBS encouraging risk-averse behaviour rather than responsible behaviour. They say it gives employers the impression that this central scheme could manage all risk out of the system used for pre-employment checking. The policy lead for disclosure and barring services at the Department of Health made the same point when she told us *“...you can’t have a central list of people held by government that are safe to work with adults or children. Just from a common sense point of view, at some point somebody is going to do something that would call into question whether they are safe or not”*. The report and recommendations of the Vetting and Barring Scheme review also highlights the need to balance responsibility to keep children and vulnerable adults safe with the rights and freedoms of individual employees and volunteers.

12.76 However, most of those we interviewed who had experience of safeguarding issues told us of their concerns about the present limitations on barring checks for staff and volunteers working in NHS hospital settings and elsewhere. All but two of the hospital trusts we visited in connection with this report told us that, notwithstanding the legal limitations on their right to require barring list checks, they were in fact continuing to require all staff and volunteers, regardless of the activities they undertook, to undergo barring list checks. The director of nursing at one of the trusts explained his thinking:

“I would rather stand up in an employment tribunal and be criticised for not letting somebody [be employed] than be in front of an inquiry panel or coroner or anybody like that. For me there isn’t even a balance to be struck...we may have deprived somebody of an opportunity, but the worst case scenario is we could

⁶⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97748/vbs-report.pdf

have deprived somebody of a life, the aspirations they may have in life, because they have been subject to...abuse or exploitation."

12.77 One of the hospitals that responded to our call for evidence told us it required all staff and volunteers to undergo barring list checks before they could work on site:

"In effect the recruitment process is as robust as it is for all staff and this is because we recognise it is not possible for volunteers to be supervised at all times."

12.78 Many staff and volunteers in NHS hospitals who do not fall within the present definitions of 'regulated activity' have legitimate reasons and regular opportunities for being in close proximity to adult and child patients and their visitors. Examples might be those who undertake tea rounds or newspaper selling rounds on wards, clinic or ward clerks, volunteers who befriend or read to adult patients, or those who supervise, entertain or teach children in hospital less than once a week. It is unrealistic to assume that they are all subject to close supervision.

12.79 Age UK, Mencap and the Ann Craft Trust all pointed out to us the inadequate recognition of the particular vulnerability of elderly and learning-disabled patients under the present 'regulated activity' regime. It is our view that the obvious uncertainties and anxieties engendered by illness and hospital treatment make most hospital patients, and the family members who visit them, vulnerable. For many people, the hospital environment alone, can be confusing and unsettling. We believe the vulnerability we refer to may increase the risks of people in hospitals being less able to protect themselves and make them more susceptible to suffering abuse of the type carried out by Savile.

12.80 Furthermore, the research literature on the characteristics and behaviour of people who commit sexual abuse suggests it is committed not only by highly motivated individuals who target organisations with the intention of abusing but also by those of lesser motivation reacting to their situation and environment⁶⁷. In their paper *Situational*

⁶⁷ For references to and consideration of that literature see Erooga, M. and others (2012) *Towards Safer Organisations II: Using the perspectives of convicted sex offenders to inform organisational safeguarding of children*.

*Theories*⁶⁸ Stephen Smallbone and Jesse Cale of the School of Criminology and Criminal Justice at Griffith University say, “*In our view, neither dispositional nor situational factors alone are sufficient to explain sexual offending. Rather, sexual offences always occur as a result of proximal interactions between individuals and situational factors.*” The paper also refers to the view of sociologists Cohen and Felson that “*For personal crimes (e.g. sexual offences) a suitable ‘target’ may be someone who is smaller, physically or psychologically vulnerable, unlikely to fight back and perhaps can be intimidated to prevent them reporting the incident*”.⁶⁹ Or, as Donald Findlater, the director of research and development at the Lucy Faithfull Foundation, put it to us: “*In the hospital situation you also have the problem that people are in beds and are unclothed. They need physical attention in terms of all manner of things, so in a way the situation provides and creates opportunities for those ill-intentioned or for those with shoddy boundaries*”. Whether a sexual offender acts as a result of disposition or in response to a situation he finds himself in, or as a combination of the two, it seems to us that patients in hospital settings are more vulnerable and likely to be at greater risk than others from the attentions of sexual abusers.

12.81 The barring lists clearly do not provide a comprehensive list of all those who might pose a threat of abusing people in hospital, and we acknowledge that Jimmy Savile, who was never convicted of sexual offences, may not have featured on the barring lists if they had existed during his time as a hospital volunteer. Nevertheless, we believe that in view of the particular vulnerabilities and risks to those in hospital settings (including the significant increase in the numbers of volunteers in hospitals and the expansion in the roles they undertake) it would be proportionate and justified to require all those who work or volunteer in hospitals and have access to patients and their visitors to be subject to barring list checks.

12.82 We accept the argument that record checks cannot and should not take the place of ‘responsible behaviours’. If we are to keep people safe from being abused then hospitals need to manage the risks of abuse through rigorous employment processes and the proper training, supervision and management of staff and volunteers, as well as appropriate access arrangements and vigilance in relation to visitors. However, we do not

⁶⁸The paper can be found here:

http://c.ymcdn.com/sites/www.ispcan.org/resource/resmgr/events/situational_theories_submitt.pdf

⁶⁹ Cohen, L. and Felson, M. (1979) *Social Change and Crime rate trends; a routine activity approach*, *American Sociological Review*, 44, 588-608.

see how the present system that subjects only some staff and volunteers with access to patients to a barring list check promotes that responsible behaviour any more than a simple blanket requirement for all staff and volunteers to be checked against the barred lists. Indeed, we believe that dealing with the complexities of the current scheme may prove a distraction from the work organisations need to do to develop their own robust and comprehensive risk management systems and culture.

12.83 The Disclosure and Barring Service told us that in the 18 months between January 2013 and June 2014 checks disclosed 157 people working or seeking work in an activity that they were barred from doing. So, although the numbers are relatively small, there is evidence that barring list checks do work to prevent unsuitable people from gaining work in 'regulated activity'. We believe that a blanket requirement for all those working or volunteering in hospital to be checked would be likely to prevent or deter even more of them.

12.84 As Richard Powley, head of safeguarding at Age UK, put it when asked for his view on 'blanket' barring list checks for all those working or volunteering in hospitals: *"We're never going to be able to stop very determined people full stop, but we can make it very difficult for them."*

Recommendation

R6 The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.

12.85 Under the present DBS system, criminal record and barring list checks on staff and volunteers are required only when they are first engaged, with no requirement for retrospective or periodic checks. The policy lead for disclosure and barring services at the Department of Health explained to us that a fixed requirement to undertake checks at stated intervals did not protect against those who might commit an offence or become subject of a barring list in the interim and placed too much reliance on central lists rather than local risk management. Good practice, she suggested, was not about employers

“checking every three years, it’s about checking when you think there is a risk”. However, many of the hospital organisations we spoke to or who responded to our call for evidence told us they required all staff and volunteers, including long-standing staff, to undertake relevant DBS checks every three years.

12.86 We accept that periodic record checking is not foolproof. There is still the risk that hospitals do not pick up on employees and volunteers who commit offences or are placed on the barring lists between such checks. Nevertheless, it is naive to assume that a wholly risk-based approach offers greater assurance in relation to record checking: large organisations are unlikely to have the resources or the opportunities to immediately identify each employee who might at a given time present a risk to others and whose records ought to be checked. As a best endeavour at ensuring that hospitals have an acceptable level of practice in relation to record-checking and as a means of maintaining public confidence in the system we recommend that all NHS hospitals should undertake periodic record checks every three years. The implementation of this recommendation should be supported by NHS Employers.

Recommendation

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

12.87 We understand that implementing our recommendations for widening the definition of those subject to enhanced DBS and barring list checks will bear cost implications for NHS trusts. We discussed the matter with representatives of NHS Employers⁷⁰ who nevertheless supported our proposal. The former chief executive of NHS Employers told us that his organisation and others employing NHS staff would welcome greater clarity and consistency across organisations in relation to disclosure and barring arrangements.

⁷⁰ As its name suggests, NHS Employers is the organisation that advises and speaks on behalf of NHS employers. It devises and supports the implementation of the Employment Check Standards.

NHS engagement with wider safeguarding systems

12.88 We interviewed a number of chairs of local safeguarding boards. They all raised concerns about how far NHS hospital trusts engaged with local safeguarding boards and local safeguarding arrangements. In particular, they expressed concerns about the extent to which NHS hospitals fulfilled their obligation, set out in the guidance *Working Together to Safeguard Children* chapter 2, to report to the local authority designated officer (LADO) any allegation that an employee working with children had harmed, or had committed an offence against a child or posed a risk of doing so. One chair of a local safeguarding children board said: “...we get very few referrals from hospitals...the perception is that LADO is mainly a local authority and schools function”. The same chair told us that 78 referrals to the LADO took place in her local authority area in 2011/2012. Of these only two referred to health professionals, one a GP and the other an ambulance clinician. She told us that there were also 78 referrals in the year 2012/2013 and only three of these were health referrals; none related to people working or volunteering in an acute hospital. The local authority area included a large multi-site teaching hospital serving an inner-city population.

12.89 Participants in our discussion event that considered how NHS hospitals should manage the risks of abuse spoke of the benefits of the LADO system. They referred to the opportunity that LADOs gave those responsible for dealing with safeguarding concerns to talk through a case with someone with significant, recent and local experience in such matters. Donald Findlater of the Lucy Faithfull Foundation also commented:

“They...will give you advice or guidance as to whether [a matter] requires a police investigation and...this is who you should be reporting it to, or whether there is a strategy meeting. They just share the responsibility.”

12.90 Steve Reeves, director of child safeguarding at Save the Children, referred to the part LADOs played in “*increasing the ability to curtail offending*”. Participants in the discussion event raised concerns about the pressures on LADOs and the need for local authorities to ensure that they were properly resourced to deal with their case loads.

12.91 A number of interviewees raised with us their concerns about how far NHS hospitals fulfilled their obligations⁷¹ to make referrals to the Disclosure and Barring Service (DBS) in respect of staff or volunteers engaged in regulated activity who posed a risk of harm to children or vulnerable adults. Janet Gauld, director of operations at DBS, told us it was difficult to say how many referrals ought to be made but she said *“considering the size of the workforce in the education sector compared to the workforce in health, there are significantly more referrals coming through in terms of education... our concern is that there are under referrals...”* A report on research undertaken in 2012 into the behaviours and circumstances that led to barring decisions by the Independent Safeguarding Authority (the forerunner of DBS) shows that health care organisations made only a very small proportion of a sample of total cases referred.⁷² Nyla Cooper, programme lead (professional standards) at NHS Employers, suggested that many NHS organisations were unclear about when they should make a referral to DBS.

12.92 Local multi-agency working arrangements to protect children and vulnerable adults are compromised if NHS organisations do not share information about those who pose a threat. Equally, it undermines the barring system if NHS organisations do not refer to DBS persons who ought to be included on a barring list. We believe NHS organisations should be fully aware of their obligations in relation to these matters.

Recommendation

R8 The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers' awareness of their obligations to make referrals to the LADO and to the Disclosure and Barring Service.

Internet and social media access

12.93 We learnt of incidents relating to the use of the internet and social media on hospital premises that raised safeguarding concerns. They caused us to question whether NHS hospitals had adequate arrangements in place to protect people in their care,

⁷¹ Under section 35 SVGA

⁷² McKenna, K. and Day, L. (March 2012) *Safeguarding in the Workplace: What are the lessons to be learned from cases referred to the Independent Safeguarding Authority?*

particularly children and young people, from the risks posed by modern information technology.

12.94 The incidents occurred at two hospitals:

Incident 1:

During the course of a consultation with a nurse, a parent let a five-year-old child view pornographic images on the parent's phone. The nurse challenged the parent, who objected to the intervention by the nurse and made a formal complaint.

Incident 2:

The behaviour of a man who had been fundraising on an independent basis for a hospital led to his being banned from the hospital premises. While he was banned he tried to befriend a child patient via social media and had asked the child to invite him into the hospital as her visitor. The child reported him to staff, who advised her to ignore his approaches.

Incident 3:

A teenage patient took photographs of other patients on a children's ward without permission and uploaded them on to a blog.

Incident 4

A doctor showed colleagues pornographic images on his iPhone. He was sacked.

12.95 Staff at the hospital where incidents 1 and 2 occurred told us that the hospital had a policy on computer and internet access use by patients and staff, but the chief nurse told us *"you can write as many [policies] as you like; it's actually policing of these things. It's having the discussion with the young people, it's being clear with them that while you're here we will be checking...we do check..."* She went on *"...society isn't with us. What we're finding is that we're probably laying down rules that their mum and dads aren't."*

12.96 Another hospital we visited had a policy about internet access and usage but it related only to staff. We discussed this with staff on the children's and young people's wards and they told us that this lack of a policy for internet use by their patients meant they had had to devise policy and rules at ward level. They too told us how implementing

their policy and restricting the use of the internet and social media sometimes put them at odds with patients and their families.

12.97 Nineteen of the twenty organisations that responded to our call for evidence on this point said they had a policy for access to the internet and social media. Thirteen said that their policy applied only to staff.

12.98 The policy lead on information, security and risk management of information services at the Department of Health, (the information policy lead), told us NHS organisations were largely autonomous in their management of IT systems and information governance but they did submit annual self-assessments on these matters and were subject to information governance oversight by the Department of Health, NHS England and the Health and Social Care Information Centre. The department supported local organisations by issuing information governance guidance. However, the Department of Health guidance on information security and governance we saw focused on the security of NHS information systems and the management of information and data by NHS staff. It did not explicitly address misuse of internet access by patients or visitors on NHS premises.⁷³

12.99 Patients in some NHS hospitals can use their own devices to access the internet as guests through the portal of the hospital's approved commercial internet service provider or via their own internet service provider. In the first case, the hospital can impose controls or blocks on certain sites or material but it cannot block the use by a patient or visitor of their own machinery or devices or their personal internet server. Even where a hospital imposes controls, they are not foolproof and may not keep pace with rapid developments in internet systems, sites and services. As the information policy lead put it: *"what safeguards there are today may not be relevant tomorrow"*.

12.100 The information policy lead agreed with us that the potential for misuse of internet access of the sort illustrated by the incidents we refer to above and the limitations of blocking and controls point to the need for hospital trusts to have consistent trust-wide policy on the acceptable use by patients and visitors of information technology and internet access. Such policy should apply to all internet use within a hospital. It should give staff the power to enforce acceptable use of information technology, the

⁷³ See *Information Security Management: NHS code of practice* (April 2007) Department of Health. *NHS Information Governance: Information Risk Management, Guidance: Social Interaction- Good Practice* (February 2012) Department of Health Informatics Directorate

internet and social media. It would need to be reviewed and updated regularly in light of the changing information technology landscape. The information policy lead also emphasised the fact that the use of the internet and information technology by patients and visitors represents a business risk to hospital trusts, especially in relation to their reputation, and trusts should manage it at board level.

12.101 The evidence we gathered shows that some NHS hospitals do not have a clear and consistent policy on managing internet and social media access by patients and visitors. Hospital organisations need such a policy to protect people on their premises from the consequences of inappropriate use of information technology, the internet and social media. Without one, staff do not have the guidance and support they need to deal with difficult issues. They may also be exposed to pressure and complaints from patients and their families, some of whom may wish to use the internet and other technology in a way that could be offensive or harmful⁷⁴.

Recommendation

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

The management of human resources

12.102 Many people working on NHS premises, including many estates and security personnel, are employed by third-party contractors. NHS Employers' employment check standards make clear that NHS trusts must seek written confirmation from a supplier of contract or agency staff that employment checks have been undertaken and that monitoring of compliance with this requirement must be part of scheduled auditing arrangements. Providers of contract or agency staff who have a national framework agreement with Crown Commercial Services (CCS) are required to give assurances about

⁷⁴ Teenage Cancer Trust's policy and terms and conditions for the use of the internet and social media by patients and their families offer a useful model.

their pre-employment processes and are subject to random auditing by CCS. However, a number of people with experience of safeguarding matters raised with us their concerns about whether contractors do in fact follow appropriately rigorous recruitment and employment processes (including DBS checking). They also questioned whether contract and agency staff received appropriate training. They told us the tendency towards a high turnover among contract and agency staff compounded their concerns. They questioned whether hospital organisations were adequately monitoring whether contractors fulfilled their contractual obligations in these respects.

12.103 The hospitals we visited sought to reassure us that they had processes to check and follow up on their contractors' compliance with their obligations in relation to the staff they supplied. One hospital also told us that all its contract staff were in any event required to undergo the hospital's own training. Nevertheless, in light of the Savile affair, and given the risks and sensitivities associated with recruiting and managing hospital staff, we urge all hospitals to review their processes for ensuring and checking that contract and agency staff are subject to appropriate recruitment and employment processes and receive adequate training.

12.104 Our investigations and the Leeds investigation have also highlighted the fact that in some hospitals responsibility for certain employment and human resources (HR) matters lies other than with the hospital's HR department. One hospital we visited explained that their contract staff, which includes their estates and security staff, were solely the responsibility of the estates and facilities department. The director of workforce and organisational development told us:

"It is all done through our director of estates and facilities, so a lot of the contracts that we put out and the tender requirements that go out include a requirement for staff to be CRB checked and they run internal processes within estates and facilities to check and follow up on that."

12.105 Similarly, the Leeds investigation report found that the trust directly employed portering and security staff but they were subject for historical reasons to separate HR processes managed by the estates and facilities department. The processes were parallel to those operated by the main HR department for all other staff but the investigation team concluded:

"...we are concerned that separate processes may make it difficult for the board to receive an overall assurance that recruitment and employment practices are operating in a consistent and robust manner. Consideration should be given to establishing a unified HR process across the organisation which fulfils the recruitment and employment requirements for all trust employees".⁷⁵

12.106 We believe the Leeds investigation team was right to identify the need for professionalism and consistency across a hospital trust in relation to the recruitment, checking and training of staff, including contract and agency staff. We understand that many organisations manage their HR function on a "business partner model" with a central HR function responsible for policy, strategic and corporate matters and separate HR managers working within and as part of separate departments. But even within this model we believe that organisations can and should ensure that processes are operated consistently and rigorously across all their departments and functions. And overall responsibility for HR matters and board assurance in relation to HR matters should ultimately rest with a single executive director. In keeping with this approach, we also believe it is right that HR processes expected of third-party contractors should be devised and compliance with them should be monitored by a hospital's professional HR managers.

Recommendations

R10 NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

⁷⁵ Leeds investigation report, p.179

13. Raising complaints and concerns

13.1 A number of those we interviewed, including the former director of the Crown Prosecution Service, talked of their concerns about the difficulties that victims face in reporting abuse, and the relatively low numbers of cases of abuse that result in prosecutions.

13.2 A recent report for the NSPCC found that many disclosures of abuse by children are either not recognised or understood or are dismissed or ignored.⁷⁶ The report authors say that their research “*had highlighted the need for greater awareness about the signs of abuse, that children do disclose but we don’t hear those disclosures*”.⁷⁷ Likewise, representatives of the Patients Association and of Age UK talked to us about the reluctance of older people to raise concerns about their care and in particular issues of abuse. Representatives of Mencap told us about the difficulties associated with enabling people with learning difficulties to report their concerns and with identifying when people with learning difficulties have been abused.

13.3 The difficulties that Savile’s victims had in reporting his abuse of them are evident in particular from the reports of the Leeds and Stoke Mandeville investigations. They show that few of Savile’s victims felt they could or should tell anyone. Most of those who did say something found that they were not believed or were ignored.

13.4 Preventing abusive and inappropriate behaviour in hospital settings requires that victims, staff and others should feel able to make a complaint or raise their concerns and suspicions, and that those to whom they report those matters are sensitive to the possible implications of what is being reported to them and escalate matters to managers with authority to deal with them.

13.5 Rt Hon Ann Clwyd MP and Professor Tricia Hart set out in the report of their review of the NHS complaints system⁷⁸ what is needed of an effective complaints system. The

⁷⁶ Allnock, D. and Miller, P. (2013) *No one noticed, no one heard: a study of disclosures of childhood abuse*.

⁷⁷ *Ibid.* p.56

⁷⁸ (October 2013) *Putting Patients Back in the Picture: A Review of the NHS Hospitals Complaint System*.

following points in that report have particular resonance with the concerns expressed to us about the difficulties people face in reporting incidences of sexual abuse:

*"Patients want a complaints system that is easy to understand and to use; that is easily accessible and does not require any particular expertise to navigate; and that takes account of the difficulties many people face in expressing themselves or giving evidence, particularly at times of stress, ill health or in bereavement"*⁷⁹

*"The way that complaints are handled should be sympathetic and sensitive and not seek to reduce, deny or marginalise people's feelings"*⁸⁰

13.6 The report makes a number of recommendations aimed at improving the present arrangements for managing complaints and whistleblowing about the quality of treatment or care in NHS hospitals. Some of the recommendations seem to us particularly helpful in promoting the sensitivity within organisations necessary to encourage the reporting and appropriate handling of complaints about sexual abuses and we endorse them:

- *"There should be annual appraisals linked to the process of medical validation which focus on communication skills for clinical staff and dealing with patient concerns positively. This goes hand in hand with ensuring that communication skills are a core part of the curriculum for trainee clinical staff"*
- *Hospitals should actively encourage volunteers. Volunteers can help support patients who wish to express concerns or complaints. This is particularly important where patients are vulnerable or alone, when they might find it difficult to raise a concern. Volunteers should be trained"*
- *PALS should be re-branded and reviewed so it is clearer what the service offers to patients and it should be adequately resourced in every hospital"*
- *Every trust should ensure any re-branded patient service is sufficiently well sign posted and promoted in their hospital so patients know where to get support if they want to raise a concern or issue"*
- *Attention needs to be given to the development of appropriate professional behaviour in the handling of complaints. This includes honesty and openness and a willingness to listen to the complainant, and to understand and work with the patient to rectify the problem"*

⁷⁹ (October 2013) *Putting Patients Back in the Picture: A Review of the NHS Hospitals Complaint System*. p.20

⁸⁰ *Ibid.* p.21

- *Staff need to record complaints and the action that has been taken and check with the patient that it meets their expectations*
- *Complaints are sometimes dealt with by junior staff or those with less training. Staff need to be adequately trained, supervised and supported to deal with complaints effectively”⁸¹*

13.7 In his recently published review, Sir Robert Francis QC considers at length how the NHS can develop a more open and honest reporting culture generally. His findings and recommendations accord with and enlarge upon much of what we learnt from our investigations.⁸²

13.8 In section 12 above we considered how, as part of a robust overall safeguarding system, organisations need to be responsive when people make complaints and raise matter of concern. In the following sections we consider other more specific matters that we believe will encourage staff, patients and others to raise the alarm in particular about sexual abuse and other inappropriate behaviours.

Policies and using the right terminology

13.9 Many people we interviewed told us that the term ‘whistleblowing’ to cover policies aimed at encouraging staff and others to speak out about matters of concern particularly in relation to abuse was unhelpful. They said the term implied a public challenge to an organisation and an assumption that the organisation or part of it would not respond positively to the matters being raised. They told us that ‘whistleblowing’ also heavily implied the possibility of legal proceedings. Vida Morris, the deputy director of clinical governance at Northumberland Tyne and Wear NHS Foundation Trust, said:

“From a staff perspective...I don’t think the term whistleblowing is particularly helpful. It has very negative connotations to it and I think it is sometimes obstructive in terms of people feeling able to come forward and raise concerns.”

⁸¹ (October 2013) *Putting Patients Back in the Picture: A Review of the NHS Hospitals Complaint System*. p.32 to 34

⁸² Sir Robert Francis QC (February 2015) *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS*.

13.10 Most of the organisations we visited and many of those who responded to the call for evidence recognised the problem with using the term ‘whistleblowing’ and had changed the name of their policy to ‘raising concerns policy’ or were using the term ‘raising concerns’ in conjunction with ‘whistleblowing’. From the perspective of seeking to encourage people to disclose the sensitive and difficult matter of abuse, we suggest that all NHS organisations need to ensure that the title and content of their policy makes clear that it applies to raising all and any concerns, whether or not they amount to matters that some might describe as whistleblowing.

13.11 The investigations at Leeds and Stoke Mandeville found widespread gossip and talk and complaint among staff at those hospitals about Savile’s inappropriate behaviour as a porter and his promiscuity and sexual harassment of female staff. But it seems that the gossip, talk and concerns of staff were not brought to the attention of senior managers. As a result managers did not prevent him from continuing to volunteer at the hospitals. These findings prompt us to suggest that NHS organisations drafting their policies and communicating with their staff about raising concerns must be explicit that staff should raise all potentially serious matters, even if they do not have hard evidence to justify their concerns. Staff should be trained and encouraged to report any matters which indicate a risk of harm to others, even if what they pass on appears to amount only to suspicion, innuendo or gossip.

A culture that supports and encourages people to make complaints and raise concerns

13.12 We discuss above the organisational values and culture required to underpin an effective safeguarding system. Certain other factors encourage the development of a culture that more specifically supports people to raise complaints and issues of concerns.

13.13 The investigations at Leeds and Stoke Mandeville found that rigid and hierarchical lines of accountability, as well as ‘silo-based’ management and complaints handling arrangements, deterred staff and patients from raising concerns about Savile. They also meant that the complaints and matters of concern raised were not dealt with appropriately. In particular they were not escalated to senior managers.

13.14 Our visits to hospitals showed us that organisations continued to face a challenge in empowering staff to feel able to raise concerns. The director of workforce at one NHS

trust we visited discussed with us the outcomes of a listening exercise undertaken with staff to discuss how they felt about challenging colleagues in higher professional roles. She told us:

"Some staff are less confident because they thought others would do [the challenge]. That made us realise that we cannot have these hierarchical differences; if people have a concern they need to raise it regardless of their banding or professional role. Tackling it involves developing a culture and the work that we are doing involves trying to breakdown some of the silo working across the whole trust engendering a more supportive culture."

13.15 Another hospital we visited was making generally commendable efforts to support staff to raise concerns. Nevertheless, junior nurses acknowledged that they would still be reluctant to raise concerns that amounted to a challenge to those they saw as in positions of authority. What we found is echoed in the Stoke Mandeville investigation report which contains the following pertinent comment:

"When interviewed by the Investigation several witnesses felt that, even today, they would be reluctant to raise concerns pertaining to staff performance for fear of reprisals".⁸³

13.16 What we heard and what we learnt from the Savile investigation reports make clear that people do not feel comfortable challenging those they see as in authority and hierarchies within hospitals are a barrier to staff raising their concerns. A number of those we spoke to said it was important to encourage staff to overcome their natural reluctance to challenge or question the behaviour of others that they see their managers as present and approachable. As Lynne Wiggins, director of nursing at Ipswich put it *"I think it is really important that the whole board gets out and about and hears directly from staff...you don't have to say very much for people to tell you exactly what is going on and what it is that is concerning them, but you do have to be out there to hear it."*

⁸³ Stoke Mandeville investigation report, para. 14.12

13.17 The director of nursing and clinical governance at the Royal Brompton and Harefield NHS Foundation trust wrote in answer to our call for evidence:

"The higher profile of safeguarding matters in society and the media as well as the NHS has led to reports and investigation of more concerns than in the past and I believe that staff in particular are clearer about their responsibilities for this aspect of care of patients, visitors and colleagues. The culture of the organisations plays a big part in this and ensuring that all staff are approachable and supportive and know what to do. This is a big challenge. The way senior staff react to a person who reports, and how they investigate and act thereafter I believe are key determinants that at best encourage and at worse deter reporting of concerns."

13.18 Helene Donnelly, who spoke to us about her experience of raising concerns about the standards of care when she was employed as a nurse by Mid Staffordshire NHS Foundation Trust, emphasised the need for all managers to be trained to deal positively and appropriately when matters of concern are reported to them. She told us that the culture in NHS organisations needs to be one where the raising of matters of concern is *"not only expected, but is accepted as well"*. Sir Robert Francis QC made the same point in an interview with us:

*"It doesn't matter how many problems or issues you have as an employer with your informant-it may be an incompetent surgeon...or whatever else it is- you must listen to what they say where it raises an issue for patient safety.
...If what is being said is potentially very serious or could lead to serious results then something must be done about it, instead of it just being brushed off as an inconvenient piece of information."*

13.19 Another important element in encouraging and supporting staff and patients to raise concerns is for organisations to ensure that they feel protected from threats or other adverse consequences if they do so. We heard of a good example of an organisation giving staff support in this way at one trust we visited. We were told about staff who had been disciplined following allegations against them of misconduct. The trust introduced managers from other parts of the organisation to the ward in question to ensure that staff and patients who had raised the alarm were not subject to retribution.

13.20 Many people we spoke to were certain that in relation to sexual harassment and sexually inappropriate behaviour in the workplace awareness and attitudes had changed markedly in recent times. They told us there was an increasing willingness to speak out against instances of such behaviour. One director of workforce told us:

"I think we have seen a massive social shift over the last 20 years. People are much more willing to speak out. There's an awful lot more people raising grievances about sexual harassment whereas 10 years ago that was less likely..."

13.21 A director of nursing told us *"there has been such a lot of heightened awareness about the importance of speaking up when you feel things aren't right and something is odd."* She went on to give us a good example of a recent case in her organisation in which a young female member of staff challenged the sexually inappropriate behaviour of a male colleague, which ultimately resulted in the male colleague being subject to disciplinary action.

13.22 Developing a culture that supports staff to raise concerns is not a simple task. It requires organisations constantly to be clear about values and expectations and regularly to reinforce the message that all staff have an obligation to report concerns and matters that may be amiss. Organisations also need to keep reviewing and refining the way they encourage and support staff to fulfil that obligation. In addition, managers need to ensure that they respond positively and appropriately when concerns are raised with them.

Providing opportunities for staff, patients and others to raise concerns

13.23 Most of the hospitals we visited demonstrated that they understood the need for flexibility in the way that staff and others can raise their concerns; that they needed to offer many and varied opportunities to ensure that they captured significant issues and concerns that posed a risk to their organisation, their patients and their staff. Birmingham Children's Hospital NHS Foundation Trust particularly impressed us with their imaginative and comprehensive suite of methods for staff, patients and their families to report on their experiences in the hospital and raise matters of concern. The chief nurse at the trust told us:

"the safeguarding process is just one route of raising a whole variety of concerns... people may not think from a harassment perspective to go to safeguarding . They may think HR. But it is our job to make sure there are lots of routes but predominantly that it is heard- that's the important thing, that we hear it ...and it isn't dismissed"

13.24 Staff at the trust told us that its arrangements included an intranet page where staff could report any issues anonymously. They had an annual open event for all staff at which they could raise issues with the whole executive team. In response to the reports in relation to Savile and Mid Staffordshire, they had set up an anonymous helpline for staff to report concerns. They had held a series of special staff forums where staff had been invited to comment on how able they felt to raise concerns. Posters and leaflets on wards told patients they could raise complaints or any issue of concern by filling out cards available on wards, by email, by text and on the trust's patient feedback app. The lead for patient experience and participation also told us how they visited some patients after they had left the hospital to gather their stories for feedback to the board and senior managers. She also described how they contacted some patients before admission to the hospital and asked them to provide feedback on their experience of their care on a "mystery shopper" basis. In addition, the trust had recently established a Trainees Advocacy and Liaison Service (TALS) based on and managed by their Patient Advocacy and Liaison Service and aimed at getting junior doctors on placements to report their concerns. Given that trainees are close to the trust operations and likely to be less inhibited than permanent staff in raising concerns, we commend the trust for trying to tap into what could be a valuable source of information.⁸⁴

13.25 Other hospitals told us they had set up email addresses to allow staff to raise their concerns anonymously. At Heatherwood and Wexham Park NHS Hospitals Foundation Trust, the former chief executive told us of her concern that patients and relatives had no channels through which to raise issues they wanted resolved out of hours. In response, she had instigated a poster campaign that identified how they could contact a duty nurse and an on-call manager. At Ipswich Hospital NHS Trust we heard about a helpline of volunteers trained to support employees, which was a conduit for raising concerns.

⁸⁴ See Sir Robert Francis QC's "*Freedom to Speak Up*" review p 177 on the need for particular measures to encourage and support students and trainees to raise matters of concern.

Raising concerns - conclusion

13.26 Our evidence suggests that many NHS hospitals are trying to promote the values and arrangements that encourage people to voice their concerns. But, as Sir Robert Francis QC's *"Freedom to Speak Up"* review has found, there is more that could and should be done. We would urge all NHS hospital organisations to continue to think imaginatively and share ideas about how they encourage feedback and the raising of concerns by staff and patients, especially from their most junior staff and their most vulnerable patients who are at greatest risk of being victims of abuse.

Mandatory reporting

13.27 Some people told us that in light of the Savile case and other recent sex abuse scandals they would welcome the introduction of a statutory duty to report suspicions about child abuse, in the same vein as the legislation applicable to Northern Ireland which makes it an offence for a person who knows or believes that any offence has been committed not to report that information⁸⁵. Most of those who discussed the issue with us were, however, against mandatory reporting. They argued that victims would be inhibited from confiding in others and reporting abuses because they could no longer do so in confidence and because they would lose choice and control over their circumstances. They also told us that professionals and others would be inhibited from sharing and discussing their suspicions about abuse for fear that the police would necessarily become involved in matters that might not justify such an intervention.⁸⁶

13.28 Mandatory reporting is an issue on which opinions differ and are deeply held. It would have significant implications for the way that professionals involved in safeguarding work. We do not think it is appropriate for us to come to conclusions on mandatory reporting purely in the context of the lessons to be drawn from one particular, historical, sex abuse scandal. This is a sensitive and specialist subject that deserves to be widely consulted upon and given thorough consideration and we welcome the government's recent announcement of a public consultation on the subject.

⁸⁵ Criminal Law Act (Northern Ireland) 1967 s 5 (1)

⁸⁶ See further arguments set out in NSPCC Policy Position Paper (January 2014) *Mandatory reporting: A consideration of the evidence*.

14. Fundraising and charity governance

14.1 The report of the Savile investigation at Stoke Mandeville hospital makes clear that Savile's fundraising on behalf of the National Spinal Injuries Centre (NSIC) played a significant part in maintaining and enhancing his access and influence. The Leeds investigation team commented that Savile's *"celebrity status and pursuit of publicity combined with his record of fundraising...are likely to have given Savile greater longevity within the Infirmary and access and influence than either of these factors alone might have done."*⁸⁷

14.2 We can find no other example in modern times of an individual fundraiser or celebrity having so much unchecked influence in NHS organisations as Savile. But his case does raise the question of how NHS hospitals manage their charitable funds, their fundraising arrangements and the role of celebrities and donors who play a part in them.

Background

14.3 Most NHS hospitals have their own associated charities, which hold charitable funds for furthering the aims of the hospital. These are known as NHS charities. NHS charities are bound by and subject to the NHS Act 2006 as well as by charity law.

14.4 Most NHS charities have a corporate trustee governance model under which the property of the charity is held by the NHS hospital itself and the hospital's board of directors act collectively as trustee for the charitable property given to it⁸⁸. A small number of NHS charities have a body of individual trustees appointed by the Secretary of State for Health to carry out their trustee functions and two hospitals⁸⁹ have recently been granted the right by the Secretary of State to establish an independent company limited by guarantee to act as trustee of their associated NHS charities.

14.5 The question of the most appropriate governance structure for NHS charities has recently been the subject of a review by the Department of Health. This review was

⁸⁷ Leeds investigation report, p.75

⁸⁸ See The National Service Act 2006

⁸⁹ Barts Health NHS Trust, Royal Brompton and Harefield Foundation NHS Trust

established in part in response to pressure from some larger NHS charities for a governance model that would give them greater independence from their associated NHS bodies and the Department of Health. As a result of the review the government will now permit all NHS charities to transfer their charitable funds to new, more independent charitable trusts regulated by the Charity Commission under charity law alone. However, NHS bodies will be able to continue to act as corporate trustee of their charitable funds established and regulated under NHS legislation if they wish to do so. The government has repealed the provisions allowing for the appointment of charitable trustees by the Secretary of State for Health and is requiring charities with appointed trustees to choose whether to transfer their funds to a new independent trust or to hold them as an NHS charity with a corporate trustee governance model.⁹⁰

Fundraising by NHS charities

14.6 Our investigations revealed wide variation in the sums generated by hospitals from charitable fundraising. Annual accounts show that nearly half of the £368m raised by the 254 NHS charities in 2012/2013 was raised by and benefited six large high-profile hospital trusts.⁹¹ By far the largest income from charitable sources is received by Great Ormond Street Hospital which in 2012/2013 received £70m, equivalent to nearly 25 per cent of the hospital trust's income from the NHS budget for patient care. In the same year the University College London Hospitals Charities had income of £35.9m and the Christie Hospital Charitable Fund received £13.2m. But most hospitals receive much smaller sums from charitable sources: 183 NHS charities reported annual income in the year 2012/2013 of less than £1m, with 120 of them receiving less than £400,000.⁹² One district general hospital we visited told us they undertook no active fundraising.

⁹⁰ Department of Health (March 2014) *Review of the Regulation and Governance of NHS Charities; Government response to consultation*.

⁹¹ Great Ormond Street Hospital Children's Charity; University College London Hospitals Charities; Barts and the London Charity; The Christie Hospital Charitable Fund; and Guy's and St Thomas' Charity, the Royal Marsden Hospital Cancer Charity. Information collated from annual accounts by the Association of NHS Charities.

⁹² Information collated from annual accounts by The Association of NHS Charities.

Savile's fundraising

14.7 Savile's charitable fundraising was undertaken via two charities, the Jimmy Savile Charitable Trust and the Jimmy Savile Stoke Mandeville Hospital Trust. These charities were separate from the NHS organisations to which they made charitable donations. They had individual trustees, including Savile, and were bound by charity law. Many individual charitable trusts like those Savile established raise funds for NHS organisations but sit outside the governance arrangements of the NHS. Many are established and managed by former patients, their families or their friends and undertake fundraising for hospitals or particular hospital services.

14.8 Savile's use of his fundraising at both Stoke Mandeville and Leeds to promote his own projects and to maintain his own access and influence prompted us to consider how NHS hospitals and their associated NHS charities ensure that their own fundraising is subject to good governance, and how they ensure appropriate management of relationships with independent charitable trusts, such as those Savile established, and with individual donors and celebrities.

Elements of good governance

14.9 We interviewed Marianne Fallon, UK head of charities at the accounting firm KPMG, and Caroline Lane, an experienced professional fundraiser who has led a number of high-profile NHS charitable fundraising projects. Both told us that the disparity in charitable funds raised by NHS charities was matched by variable standards of professionalism and governance arrangements; those charities that raised most were likely to have the greatest interest in and capacity for ensuring that they undertook their fundraising and managed their charitable funds to the highest professional standards.

14.10 Caroline Lane told us:

"There is no hard and fast rule with all these charities because there are such different levels of sophistication within the individual hospitals and their charities, there isn't a standard format that everyone works to for fundraising"

14.11 Marianne Fallon, UK head of charities at KPMG, considered with us the elements required to ensure that fundraising by NHS charities was managed *“from a best practice perspective”*. The first element was proper risk management to ensure not only the protection of charitable assets and funds raised but also protection of the good name and reputation of the charity. Marianne Fallon said:

“from a best practice perspective...fundamentally it’s about risk management for me. If you are entering a relationship with somebody who is either going to be raising money for you on your behalf or indeed giving you some kind of income stream, whether it is corporate sponsorship or whatever, you would expect that there would be an appropriate degree of rigour around the risk assessment of that...because ultimately under charity law the charity trustees have a legal duty to protect the assets of the charity. That isn’t only about making sure that the pounds and pence are spent on the right thing. The biggest asset the charity has, obviously, is its brand and its reputation....sometimes a charity can be playing catch up because someone may have publicly said “I am raising money for Charity A” without that charity having been aware of it”.

14.12 The fate of Savile’s own charities graphically illustrates the damage that can be done to a charitable cause by association with a person held in disrepute. Savile’s nephew, Roger Foster told us:

“There is about, I don’t know, £40million probably in the various charitable trusts. We cannot do anything with it at the moment because nobody wants to know. You ring up and say ‘I’m a trustee of the Jimmy Savile Charitable Trust’. ‘Thank you very much’ and the phone goes down again, they are not interested because it is toxic. If you take money from that some other benefactor might turn around and say, ‘Well, I’m sorry we are pulling out because you are taking money from there’. It is a very tragic state of affairs, it really is because there is money there that could be so useful to help people.”

14.13 In considering the risks to an NHS charity and to the NHS organisation it seeks to benefit, trustees and hospital management must look at their relationships not only with celebrities but also with major donors, commercial partners and with other charitable organisations and interests that benefit the charity or the hospital or occupy its site.

14.14 Two NHS hospitals that we spoke to received a significant income from their NHS charity and shared with the charity clear and documented policies and risk-assessment processes for managing these relationships and for protecting their organisation's brand and reputation. However, this was not the case with most of the organisations we had contact with, though some were beginning to examine and formalise their arrangements in the light of the Savile affair.

14.15 For example, one high-profile NHS organisation that used celebrity endorsement in its publicity campaigns and another which had significant associations with celebrities and commercial partners, and a large income from charitable sources received via an associated NHS charity, had no formal policies for managing and assessing the risks to their 'brand' and their relationships with celebrities and others. They did not include the issue of brand and reputation management in their risk registers. In the case of the latter organisation however, the related NHS charity did operate under a policy on the acceptance of charitable gifts and did refer doubtful gifts to an ethics review group. The head of corporate affairs at one of these organisations explained that brand management was the responsibility of the organisation's communications department and the board as a whole discussed issues such as the type of commercial ventures the organisation would be prepared to enter into:

"We've had discussions about what countries we would be prepared to do business with. We have a general policy that we won't deal with people who don't have a good record in human rights including torture...The brand is protected and is quite proudly protected by the board and on the board's behalf by the communications department".

14.16 He confirmed that the brand was not included on the risk register, which he explained thus:

"I don't think the brand is regarded as a general risk on the risk register because we haven't any track record of the brand actually being abused in any way that cannot be dealt with and nipped immediately in the bud."

14.17 A number of the management teams at other NHS hospital trusts we spoke to said they had informal discussions about reputational risks as necessary, including whether to form associations with individual celebrities, donors and commercial partners. Some said

they had no need of formal arrangements in this respect because of the limited nature of their fundraising activity. We believe, however, that staff with little or no experience of managing relationships with celebrities, major donors or commercial sponsors are at greatest risk of being 'star struck' and of mishandling such relationships and must be able to refer to guidance in a formal policy.

14.18 Nearly all the NHS organisations we spoke with said they would like to increase their income from charitable fundraising, especially given likely future pressure on budgets. In the event of increased charitable fundraising by NHS organisations, brand and reputation management and protection will become all the more pertinent. Moreover, most hospitals, including those with limited fundraising activity, told us they received and benefited from occasional visits from celebrities simply for the purpose of boosting staff and patient morale.

14.19 We believe that most NHS organisations and their linked NHS charities are exposed, and will become increasingly exposed, if they do not have clear policies and procedures for assessing and managing the risks to their brand and reputation from associations with celebrities, donors and others.

Recommendation

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

14.20 The second element of good governance Marianne Fallon spoke about was the need for NHS charitable trusts to be managed and structured so that they act independently in the best interests of the charity and its purposes. She told us:

"that is not to say there can't be some - and often you would expect there to be some - representation from the NHS trust itself, but the board of the charity should ultimately be comprised so that it can demonstrate and is in practice independent and its own decision - maker."

14.21 She went on:

"I suppose one of the challenges for any charity is that they can clearly demonstrate in practice the power of the board from a governing perspective is working appropriately, i.e. it isn't one person who is effectively driving through decisions and the rest of the board are just nodding through their wishes. That goes back to each individual trustee's responsibilities under charity legislation to individually - and jointly, but individually - make decisions in the best interests of the charity, protect the assets of the charity and make decisions which balance the interests of the current beneficiaries with those of the future."

14.22 Whichever of the models referred to in paragraph 14.5 is adopted for the governance of NHS charitable funds, trustees will need to ensure and demonstrate that they act appropriately, that one trustee does not dominate their decision-making and that the decisions are guided only by the best interests of the charity.

14.23 As we explain, the Jimmy Savile Stoke Mandeville Hospital Trust was not an NHS charity but its associations with Stoke Mandeville Hospital clearly demonstrate the dangers for any NHS organisation of being associated with a charity in which one individual dominates decision-making and uses their control over charitable funds to further their own personal agenda and influence.

14.24 The Stoke Mandeville investigation report shows how Savile's position in the Stoke Mandeville Hospital Trust gave him the opportunity to interfere in issues ranging from the choice of contractors used to build the NSIC to the type of carpet laid in the centre, sometimes with unhappy consequences. And his control over the significant charitable funds held for the benefit of the hospital allowed him to maintain a presence and influence in that organisation long after he had become unwelcome there. The Stoke Mandeville investigation report says:

"Witnesses told the Investigation that between 1983 and 1990, Savile demonstrated virtually uncontested authority and control at the NSIC...It had been thought that Savile's intense interest in the NSIC would decrease once the building had been opened; this did not happen. Instead Savile took up residence in his own office suite at the NSIC from where he 'held court' and continued to manage the Jimmy Savile Stoke Mandeville Trust Fund...From an early stage Savile was of the

view that he 'owned' the NSIC and as such had the right to manage its affairs as he saw fit. Savile was able to maintain a tight grip on affairs as the NSIC continued to be dependent upon his Charitable Trust Funds."⁹³

14.25 Besides the governance considerations we discuss above, the best interests of an NHS charity and the fulfilment of its objectives also require a shared understanding between a donor charity and the hospital management about the service needs and priorities of the hospital. As Caroline Lane put it:

" it would be an absolute disaster if we raised millions of pounds for [an] item of equipment and then found that the hospital couldn't use that item because a proper business case had not been put together that looked at things likestaffing, training of staff, maintenance, all the extra costs that carry on.."

14.26 We heard of instances of tensions between NHS charities and the hospitals they supported over the way charitable funds were applied. Marion Allford, an experienced professional fundraiser who now acts as a consultant for fundraising projects, suggested that such tensions were quite common. Amanda Witherall, the chief executive of the Association of NHS Charities, pointed out that the fault can lie with either party:

"Unfortunately there are some instances where tension exists between the NHS charity and the parent hospital's board. Sometimes this is down to poor communications and lack of engagement and either party (or both) can be at fault here. This can result in the hospital board getting frustrated and thinking 'the charity is just hanging on to the money and not spending it as they should'. Equally the charity often feels the hospital just sees it as a 'slush fund' to be used whenever things get a bit tight and don't fully appreciate the need to plan charitable expenditure properly."

14.27 The key to minimising the risk of such tensions is continuous engagement between a hospital trust's managers and its charity trustees to ensure a common understanding of the needs and priorities of the hospital and where the charitable funds can be appropriately applied to best effect to support them. As William Colacicchi, a solicitor and

⁹³ Stoke Mandeville investigation report, paras. 12.75-12.76

chair of the Association of NHS Charities, put it: *“it is about communication”* and *“encouraging people to the right behaviours”*. He also pointed out:

“As charity trustees, you already have a duty to spend your money; as a matter of law you are not allowed just to sit on it, you have to spend it. Generally, you have to spend it within the [the hospital] trust, so you actually have a duty to talk to your [hospital] trust to work out how to spend it effectively. I’m not sure there is additional legislation or rules you can apply which will really enhance that duty, because I think it already exists and it is a question of highlighting rather than expanding it.”

14.28 Marion Allford gave us an example from a London hospital of good practice for ensuring that the hospital and its NHS charity worked together constructively in the interests of patients.

“There were joint steering groups with the chairman and chief exec and medical director and the key trustees coming together at least twice a year. The purpose of these meetings was for the hospital to keep the trustees up to date with the charity’s progress and how charitable funding had been spent, to be informed on the key issues and future plans and to explain where charitable funding would be most beneficial for patients. This allowed trustees to question the hospital representatives on these issues and to discuss with them the options for future charitable projects, before deciding which projects they would select for fundraising or grants. If trustees are kept in tune with the hospital’s vision for the future, the role they can play can be maximised”

14.29 The Stoke Mandeville investigation report shows that tensions arose between Savile and managers at the hospital about the use of charitable funds and that Savile was able to use his control of charitable funds inappropriately to influence the way services were provided. In the light of this we would urge all charities linked to NHS hospitals to consider whether they are structured and at all times operate in such a way as to further their charitable purposes. We also urge NHS hospital trusts and their associated NHS charities to consider how best to engage with each other to ensure a common understanding and respect for each other’s purposes and priorities.

15. Observance of due process and good governance

15.1 As the investigations at Broadmoor and at Stoke Mandeville show, Savile's involvement with those hospitals was supported and facilitated by ministers or senior civil servants. At Broadmoor they appointed him to the task force that ran the hospital for a period between 1988 and 1989. At Stoke Mandeville they appointed him to oversee the fundraising for and the building of the new National Spinal Injuries Centre. In appointing Savile to these roles and in allowing him the licence and free rein he had in exercising these roles ministers and/or senior civil servants either overrode or failed to observe accepted governance processes. A good example of the outcomes of this was that the group managing the rebuilding of the NSIC, led by Savile, was able to ignore usual procurement procedures in appointing contractors, and two of the trustees of the charitable funds which financed the building were involved in awarding contracts to their own firms.

15.2 It is not within the scope of our terms of reference to investigate and pronounce on the weighty issue of when and on what terms it is ever justified for those at the heart of government to waive the machinery and procedures of good governance or to invite outsiders including celebrities to engage in public service management. However, in the context of NHS hospitals, the Savile case vividly illustrates the dangers of allowing an individual celebrity to have unfettered access or involvement in management, and of not ensuring that good governance procedures are followed at all times and in all circumstances.

15.3 We make recommendations in this report which are aimed at dealing explicitly with some of the shortcomings in hospital governance processes at a local level that allowed the Savile scandal to occur. They include recommendations that celebrities should not be exempt from standard procedures governing access to patients; that contacts between NHS organisations, including NHS charities, and celebrities should be subject to careful consideration and risk management; and that all volunteers should be subject to proper selection, supervision and management processes. But ministers and officials have a responsibility to ensure that hospital managers are able to implement and adhere to these recommendations, and they should not undermine the processes of good governance and local management.

16. Ensuring compliance with our recommendations

16.1 The following recommendations are addressed to:

- Monitor and the Trust Development Authority under their duties to regulate NHS hospital trusts;
- The Care Quality Commission under its duties and powers to regulate and assure the quality and safety of hospital services; and
- NHS England under its duties and powers to promote and improve the safeguarding of children and adults.

Recommendations

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts, (and where applicable, independent hospital and care organisations) comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11 above.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12 above.

17. Conclusions

17.1 Savile was a highly unusual personality whose lifestyle, behaviour and offending patterns were equally unusual. As a result of his celebrity, his volunteering, and his fundraising he had exceptional access to a number of NHS hospitals and took the opportunities that that access gave him to abuse patients, staff and others on a remarkable scale. Savile's celebrity and his roles as a volunteer and fundraiser also gave him power and influence within NHS hospitals which meant that his behaviour, which was often evidently inappropriate, was not challenged as it should have been. Savile's ability to continue to pursue his activities without effective challenge was aided by fragmented hospital management arrangements; social attitudes of the times, including reticence in reporting and accepting reports of sexual harassment and abuse, and greater deference than today towards those in positions of influence and power; and less bold and intrusive media reporting.

17.2 While it might be tempting to dismiss the Savile case as wholly exceptional, a unique result of a perfect storm of circumstances, the evidence we have gathered indicates that there are many elements of the Savile story that could be repeated in future. There is always a risk of the abuse, including sexual abuse, of people in hospitals. There will always be people who seek to gain undue influence and power within public institutions including in hospitals. And society and individuals continue to have a weakness for celebrities. Hospital organisations need to be aware of the risks posed by these matters and manage them appropriately.

17.3 In this report we describe the values, management arrangements and processes that organisations need to have in place if they are to tackle the issue of abuse in hospital settings. We set out what we have found out about NHS hospitals' present values, arrangements and processes and the weaknesses in them. We make recommendations which we hope will lead to all NHS hospitals reviewing their arrangements and to the tightening up of procedures and processes. However avoiding events similar to the Savile case depends in large part on human behaviour and on individuals taking responsibility for ensuring that they and those around them, whatever their role and status, adhere to agreed policy and do not overstep the boundaries of sensible and acceptable behaviour. This will not result from merely changing policies and procedures or a one-off exercise to examine and assure present safeguarding arrangements: it requires repeated

reinforcement of messages, awareness - raising and training, as well as regular ongoing testing of the effectiveness and relevance of safeguarding arrangements.

17.4 Our report is only one of several that have recently been commissioned into cases of sexual and other abuses and the handling of them by public bodies. We have endeavoured to share our thinking and findings with those who have undertaken or are undertaking such other investigations or with a remit to oversee relevant areas of public policy and services. We hope to continue to engage with them in order to ensure a coherent and effective response to all the issues of abuse that are being exposed and examined, and that the recommendations that we and others make are properly implemented.

Biographies

Kate Lampard CBE

Kate Lampard spent 13 years in practice as a barrister, before moving into the public sector, where she held a number of non-executive appointments. She now undertakes investigation and consultancy work related to organisational, management and service arrangements and their effectiveness.

Kate has previously been the chair of the South East Coast Strategic Health Authority, vice chair of the South of England Strategic Health Authority and a non-executive director and vice chair of the Financial Ombudsman Service Limited. She is a trustee of the Esmee Fairbairn Foundation.

Ed Marsden

Ed has a clinical background in general and psychiatric nursing and NHS management. He has worked for the National Audit Office, the Department of Health and the West Kent Health Authority where he was director of performance management. He combines his responsibilities as Verita's managing partner with an active role in leading complex consultancy. He has recently advised the Jersey government about the inquiry into historical child abuse. Ed is an associate of the Prime Minister's Delivery Unit where he has carried out three assignments on immigration.

Letters from Right Honourable Jeremy Hunt MP, Secretary of State for Health, to Kate Lampard

*From the Rt Hon Jeremy Hunt MP
Secretary of State for Health*



Richmond House
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healthsofs@dh.gov.uk

IMC: 8733

Kate Lampard



29 October 2012

Dear Kate,

OVERSIGHT OF THE DEPARTMENT OF HEALTH AND NHS REVIEWS INTO JIMMY SAVILE

You have been in discussion with Una O'Brien about providing oversight of the Stoke Mandeville, Leeds General Infirmary and Broadmoor inquiries as well as the Department of Health's inquiries into the appointment and role Savile held at Broadmoor Hospital. I am very grateful that you have agreed to take on this important role.

I would like you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interests of patients.

Your appointment will end once internal inquiries in the Department of Health and the trusts have been pursued, an agreed conclusion and account of events has been reached and you have assured me as to the robustness of the process that was followed to reach these conclusions. Any potential other work beyond that will be determined at the time. It is planned that your advice on the robustness of the reviews undertaken and the reviews themselves will be made available to the public.

I have instructed officials to give you the support you need on this and I will make myself available to you should you so wish.

Yours ever

JEREMY HUNT

SC2910123

*From the Rt Hon Jeremy Hunt MP
Secretary of State for Health*



POC1_738163

Kate Lampard



*Richmond House
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SW1A 2NS*

*Tel: 020 7210 3000
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Dear Kate,

12 NOV 2012

Thank you for sharing the letters that you sent to Stoke Mandeville Hospital, Leeds General Infirmary, Broadmoor Hospital and the Department of Health, outlining your expectations of them in their reviews into Jimmy Savile's role and conduct in the organisations.

When I appointed you, I asked you to satisfy yourself that the Department and the relevant NHS organisations are taking all necessary steps to establish the truth and are following a robust process aimed at protecting the interest of patients. The framework that you have produced provides useful detail on how you will work with the organisations to do this. It clearly sets out your expectations and begins to shape the robust process that is required for this essential work.

It is inevitable that as you sample and assure yourself that the processes the organisations have followed are robust, you will identify themes. I would therefore like to ask you to look too at NHS wide procedures in the light of the findings and recommendations of the reviews you are overseeing once they have been completed, seeking expert advice as necessary, and see whether they need to be tightened. If so, I would very much like you to advise me on how any relevant guidelines or procedures need to be changed.

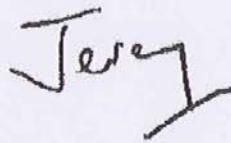
I am particularly interested in whether any inappropriate access that Savile was given was because of his celebrity or his fundraising role.

Some individuals have recently raised concerns about whether your processes will be sufficiently independent. I am clear that you are the right person for the job and you have my full confidence but I want to

make it explicit that I have appointed you in an independent capacity and I want to receive your independent views.

At the end of the process, I will publish your reports to me on both issues.

Yours ever,

A handwritten signature in black ink that reads "Jeremy". The letters are cursive and slightly slanted to the right.

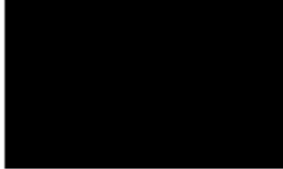
JEREMY HUNT

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health



POC1_743970

Kate Lampard



Richmond House
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- 6 DEC 2012

Dear Kate,

The Police have recently brought it to the Department's attention that Jimmy Savile may have offended in a number of NHS institutions in addition to Broadmoor, Stoke Mandeville and Leeds General Infirmary.

From the very limited information they have shared at this stage, it appears that these involved one or two alleged incidents at each trust and they happened at institutions where Jimmy Savile did not have the responsibilities or access afforded to him at the organisations who are already conducting investigations. The Trusts, who have only recently been notified, are contacting the Police and will be investigating any allegations passed to them.

Unless further information subsequently comes to light I am not asking you to oversee these further investigations, but I would like to ask you to make contact with the organisations to ask for their conclusions about the circumstances of any abuse. I believe these may form an important part of your report into common themes relating to the abuse in the NHS. I attach a list of the information that we have at this stage and I will ask my officials to keep you updated if the police share further information.

*Yours ever
Jeremy*

JEREMY HUNT

Annex: Details provided by the police on 29 November regarding additional abuse in the NHS

	Institution	Number of offences
1	St James Teaching Hospital - same trust as the LGI	1
2	High Royds Psychiatric Hospital (closed 2003 and services moved into Leeds community services)	1
3	Dewsbury Hospital (now part of Mid Yorkshire NHS Trust)	2
4	Wycombe General Hospital (now part of Buckinghamshire Healthcare NHS Trust) – same trust as Stoke Mandeville	1
5	Great Ormond Street Hospital NHS FT	1
6	Ashworth Hospital NHS High Secure Unit*	1
7	Exeter Hospital (part of Royal Devon & Exeter Hospital NHS FT)	1
8	Portsmouth Royal Hospital (now closed and facilities part of Portsmouth Hospitals NHS FT)	1
9	Springfield Hospital (now closed and facilities part of South West London and St George's Mental Health NHS FT)	2 - <i>Offences were carried out by Johnny Savile (brother). Jimmy Savile is not known to involved.</i>

*At the time of the offence, Asworth Hospital NHS High Secure Unit was run by the Department of Health

One allegations only at this stage at each of the following

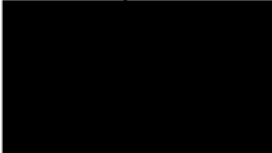
- Royal Victoria Infirmary, part of Newcastle Hospitals NHS FT
- Bethlem Royal and Maudsley Hospitals, part of South London and the Maudsley FT
- St Catherine's Hospital, Birkenhead, part of Wirral Community Trust
- Saxondale Mental Health Hospital, Notts (closed 1988)



Department
of Health

POC1_822439

Kate Lampard



*From the Rt Hon Jeremy Hunt MP
Secretary of State for Health*

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15 NOV 2013

Dear Kate,

JIMMY SAVILE INVESTIGATIONS: REVISED TERMS OF REFERENCE

I am writing to you with revised terms of references for your remaining work on the Jimmy Savile investigations in relation to the NHS, to reflect the recent announcement of potential further evidence relating to other hospitals.

On 14 October, I announced a further review of evidence by the Metropolitan Police in a Written Ministerial Statement (WMS). The review is nearing completion and in the WMS we committed to publish a list of further hospitals involved. In addition to the three main NHS investigations you are currently overseeing, I would be grateful if you could provide general assurance of the quality of all the reports relating to any new investigations, as well as the 10 NHS investigations on-going since April, in your final assurance report.

The Department of Health will be sending out guidance to the new Trusts about how they should proceed with their investigations shortly.

Verita has been asked to review reports for the 10 NHS investigations plus the investigation by Sue Ryder commissioned since April, as well as for any new investigations, in order to ensure a consistent and thorough approach is adopted.

As I made clear in the Written Ministerial Statement, the final reports of all the investigations will aim to be completed by June 2014, with publication sooner if that is possible.

I would also be grateful if your final summary report of lessons learned also included any learning from the 10 investigations and the new investigations.

I am grateful for your on-going work to ensure the investigations about Jimmy Savile's activities are as thorough as possible.

Yes

Jay

JEREMY HUNT

List of interviewees

The authors thank all those listed below for agreeing to be interviewed. The authors also thank the staff who managed their visits to the named hospitals.

This list gives job titles or descriptions correct at the date of interview.

- Donald Findlater, director of research and development, Lucy Faithfull Foundation
- Sir Thomas Hughes-Hallett, former chief executive, Marie Curie Cancer Care
- Caroline Lane, professional fund raiser
- Marianne Fallon, partner, UK head of charities, KPMG
- Maria da Cunha, director of people, legal and government and industry affairs, British Airways
- Paul Milliken, vice president - human resources, Shell UK
- Peter Carter, chief executive and general secretary, Royal College of Nursing
- Leonie Austin, director of communications, NHS Blood and Transplant
- David Evans, director of workforce, NHS Blood and Transplant
- Gary Hughes, assistant director of corporate communications, NHS Blood and Transplant
- David Spicer, former senior local authority lawyer, independent serious case reviewer
- Christine Humphrey, qualified nurse, former NHS manager, independent advisor on safeguarding and children's services
- Hilary McCallion, former director of nursing and education, South London and Maudsley NHS Foundation Trust
- Jackie Craissati, consultant clinical and forensic psychologist, Oxleas NHS Foundation Trust
- Dame Donna Kinnair, worked in child protection services in the NHS for over ten years
- Nyla Cooper, programme lead for professional standards, NHS Employers
- Dean Royles, chief executive, NHS Employers
- The policy manager for the disclosure and barring service, Department of Health
- Amanda Witherall, chief executive, Association of NHS Charities

- William Colacicchi, chairman, Association of NHS Charities
- Janet Gauld, director for operations (barring), Disclosure and Barring Service
- Stephen Bruschi, head of learning disability development, NHS England, London region
- Marion Allford, former director of the “Wishing Well Appeal” for Great Ormond Street Children’s Hospital
- Louise Hadley, director of fundraising and corporate affairs, The Christie NHS Foundation Trust
- Peter Davies, chief executive, Child Exploitation and Online Protection Centre
- Michael Watson, director of advice and information, The Patients Association
- Mary Cox, Age UK
- Richard Powley, head of safeguarding, Age UK
- Bella Travis, policy officer, Mencap
- Lynda Rowbotham, head of legal advice, Mencap
- Dr Jenifer Harding, independent chair, Sandwell Safeguarding Children and Adult Boards
- Deborah Kitson, chief executive, Ann Craft Trust
- Helene Donnelly, cultural ambassador, Staffordshire and Stoke on Trent Partnership NHS Trust
- Dr Justin Davis Smith, executive director of volunteering and development, National Council for Voluntary Organisations
- Peter Finch, chair, National Association for Healthcare Security
- Project manager, Department of Health
- Dominique Black, regulatory policy manager, Care Quality Commission
- Sir Robert Francis QC
- Peter Saunders, chief executive, National Association for People Abused in Childhood
- Carol Rawlings, chair, National Association of Voluntary Services Managers
- Richard Hampton, head of external engagement and services, NHS Protect
- Jane Walters, director of corporate affairs, King’s College Hospital NHS Foundation Trust
- Katherine Joel, head of volunteering, King’s College Hospital NHS Foundation Trust
- Reverend Adrian Klos, senior chaplain, Hull and East Yorkshire Hospitals NHS Trust
- Fiona Skerrow, voluntary services manager, Hull and East Yorkshire Hospitals NHS Trust
- The policy lead on governance policy - security and risk, Department of Health

- Deputy director people, communities and local government, Department of Health
- Social investment and volunteering policy manager, Department of Health
- Kristen Stephenson, volunteer management and good practice manager, National Council for Voluntary Organisations
- Elisabeth Harding, director family, volunteer and interpreter services, Boston Children's Hospital, USA
- Is Szzoneberg, head of social action and volunteering Scotland and England, CSV
- Deputy director and head of social action, Cabinet Office
- Head of health, ageing and care, Cabinet Office
- Olivia Butterworth, patient and public voice and information, NHS England
- Kathrin Ostermann, director of supporter development, King's Health Partners
- Professor Alexis Jay, lead for the *Independent inquiry into child sexual exploitation in Rotherham*
- Chief Constable Simon Bailey, lead for child protection and abuse investigation, Association of Chief Police Officers
- Dave Shaw, deputy director of services, Teenage Cancer Trust
- Two witnesses who gave evidence but did not wish to be named

Savile's family

- Roger Foster and Amanda McKenna

Birmingham Children's Hospital NHS Foundation Trust

- David Melbourne, interim chief executive
- Michelle McLoughlin, chief nurse
- Pam Rees, named nurse for child protection
- Jane Powell, common assessment framework lead
- Louise Kiely, head of facilities
- Bryan Healy, head of risk
- Gaby Insley, head of communications
- Vikki Savery, fundraising manager
- Janette Vyse, lead for patient experience and participation
- Fiona Reynolds, deputy chief medical officer

- Gwenny Scott, company secretary
- Alison Stanton, patient relations manager
- David Scott, associate director of governance
- Theresa Nelson, chief officer for workforce development

Guy's and St Thomas' NHS Foundation Trust

- Eileen Sills, chief nurse and director of patient experience
- Peter Allanson, trust secretary and head of corporate affairs
- Deborah Parker, deputy chief nurse
- Mala Karasu, adult safeguarding lead
- Debbie Saunders, named nurse for safeguarding children
- Amanda Millard, group director operations
- Jayne King, head of security
- Ann McIntyre, director of workforce and organisational development
- Anita Knowles, director of communications

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

- Philippa Slinger, chief executive
- Thomas Lafferty, director of corporate affairs
- Paul Rowley, director of facilities
- Mike Stone, fundraising and volunteers manager
- Jane Chandler, associate director of nursing

Ipswich Hospital NHS Trust

- Nick Hulme, chief executive
- Lynne Wigans, director of nursing and quality
- Beverley Rudland, complaints, PALS and bereavement team manager
- Sarah Higson, patient experience lead
- Dr Rob Mallinson, medical director
- Cindie Dunkling, named nurse for safeguarding children

- Julie Fryatt, director of human resources
- Linda Storey, trust secretary
- Sue Pettitt, clinical education and workforce development lead
- Jeff Calver, associate director of estates

Medway NHS Foundation Trust

- Mark Devlin, chief executive
- Dr Gray Smith-Laing, outgoing medical director
- Dr Philip Barnes, incoming medical director
- Dr Richard Patey, named doctor for child safeguarding
- Suzanne Winchester, named nurse for child safeguarding
- Steve Hams, chief nurse
- Tracey Sharpe, safeguarding vulnerable adults coordinator
- Suzanne Brooker, head of patient experience
- Zoe Goodman, voluntary services manager

Northumberland, Tyne and Wear NHS Foundation Trust

- Dr Gillian Fairfield, chief executive
- Angela Faill, caldicott police and court liaison lead
- Dr Suresh Joseph, executive medical director
- Gary O'Hare, executive director of nursing and operations
- Lisa Quinn, executive director of performance and assurance
- Vida Morris, deputy director of clinical governance
- Lisa Crichton-Jones, acting executive director of workforce and organisation

Kate Lampard's letter to all NHS trusts, foundation trusts and clinical commissioning groups (CCG) clinical leaders

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

NHS England Publications Gateway Ref No: 00056

To:

All Chairs and Chief Executives of

- NHS Trusts in England
- NHS Foundation Trusts in England
- CCG Clinical Leaders

Copies to:

- Chief Executives of Local Authorities in England
- CCG Accountable Officers
- NHS England Regional Directors
- NHS England Area Directors
- Barbara Hakin, NHS England

2 May 2013

Dear colleagues

Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile

You may recall that Sir David Nicholson wrote to you in December about my role in overseeing the NHS investigations into allegations of sexual abuse by Jimmy Savile at Stoke Mandeville Hospital, Leeds General Infirmary and Broadmoor Hospital. Sir David asked you to review your own arrangements and practices relating to vulnerable people, particularly in relation to safeguarding, access to patients including that afforded to volunteers and celebrities and listening to and acting on patient concerns.

As the second stage of my oversight work, the Secretary of State for Health has asked me to identify the themes and issues arising from the three investigations and look at NHS-wide procedures in the light of the findings of those investigations.

I am therefore interested to hear from NHS staff about the following matters:

- safeguarding - how policies, procedures and practice take account of and affect patients, visitors and volunteers within NHS settings
- governance arrangements in relation to fundraising by celebrities and others on behalf of NHS organisations

- celebrities – the use and value to NHS organisations of association with celebrities, including in relation to fundraising, and the privileges, including access, accorded to them by NHS organisations
- complaints and whistle blowing – how and to what extent do policies and procedures and the culture of NHS organisations encourage or discourage proper reporting, investigation and management of allegations of the sexual abuse of patients, staff and visitors in NHS settings.

I would also like to hear from NHS staff if they have evidence or information about their own or their organisation's dealings with Jimmy Savile that has not yet been shared with any of the teams investigating the alleged sexual abuses by Jimmy Savile on NHS premises. Such evidence or information might include local factors or matters relating to the culture of the organisation that might have facilitated Jimmy Savile's abusive behaviour.

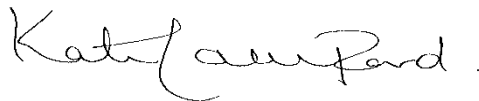
I should be grateful if you would use your own communication networks to let your staff know that they can contact me with information on the following email account:

lampardcomments@dh.gsi.gov.uk

It would be appreciated if you could send in any information by 30 June 2013.

Many thanks for your cooperation.

Yours sincerely



Kate Lampard

Kate Lampard, appointed to oversee the NHS and Department of Health investigations *Ed Marsden, managing partner of Verita, appointed to support the oversight work*

Diary management c/o Denyse Lea
Telephone: 01293 778801 Email: denyse.lea@southeastcoast.nhs.uk

Secretariat support c/o Verita, 53 Frith Street, London, W1D 4SN
Telephone: 020 7494 5670 Fax: 020 7734 9325

List of organisations or individuals who responded to our call for evidence

NHS organisations

- 2gether NHS Foundation Trust
- Airedale NHS Foundation Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Birmingham Community Healthcare NHS Trust
- Black Country Partnership NHS Foundation Trust
- Bolton NHS Foundation Trust
- Brighton and Sussex University Hospitals NHS Trust
- Cambridge University Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust
- Croydon Health Services NHS Trust
- Derbyshire Healthcare NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- East Cheshire NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Gateshead Health NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Homerton University Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Ipswich Hospital NHS Trust
- James Paget University Hospitals NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Lincolnshire Community Health Services NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust

- Mid Essex CCG
- Mid Staffordshire NHS Foundation Trust
- NHS Basildon and Brentwood CCG
- NHS Bexley CCG
- NHS Merton CCG
- NHS Sutton CCG
- NHS Walsall CCG
- NHS Waltham Forest CCG
- NHS Wandsworth CCG
- NHS West Essex CCG
- Norfolk and Suffolk NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- North Bristol NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Pennine Care NHS Foundation Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Royal Brompton and Harefield NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Shropshire Community Health NHS Trust
- South Devon Healthcare NHS Foundation Trust
- St George's Healthcare NHS Trust
- Stockport NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- The Friends of Charing Cross Hospital
- The Hillingdon Hospitals NHS Foundation Trust
- The Pennine Acute Hospitals NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust
- The Walton Centre NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Leicester NHS Trust

- University Hospitals of Morecambe Bay NHS Foundation Trust
- University Hospital of North Staffordshire NHS Trust
- University Hospital of South Manchester NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Wirral Community NHS Trust
- Wye Valley NHS Trust
- Yorkshire Ambulance Service NHS Trust

Other organisations

- CPS strategy and policy directorate
- The Association of Directors of Children's Services Ltd

Individuals

- 10 x individuals

Documents reviewed

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Bingham, A. (June 2014) *How did he get away with so much for so long? : The press and Jimmy Savile*. Opinion Article, History and Policy.

Bristol Royal Infirmary Inquiry Secretariat report (June 2000) *Reforming the NHS: policy changes and their impact on professional and managerial organisation and culture 1984-1995*.

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Department for Children, Schools and Families (DCSF) (March 2009) *Guidance for Safer Working Practice for Adults who work with Children and Young People in Education Settings*.

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Disclosure and Barring Service (December 2012) Factsheets:

- Referral and barring decision-making process.
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- Regulated Activity - adults
- Regulated Activity - children
- Prescribed Information for a Supervisory Authority

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Galea, A. and others (November 2013), *Volunteering in acute trusts in England; Understanding the scale and impact.* London: The King's Fund

HM Government (March 2013) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.* The Stationery Office, London.

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Home Office and Department of Health (March 2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse.* Department of Health.

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Munro, E. (January 2001) *The Munro Review of Child Protection, Part One: A Systems Analysis.* Department for Education.

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Smallbone, S. and Cale, J. *Situational Theories.* School of Criminology and Criminal Justice, Griffith University.

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The Health Foundation (August 2013) *Quality improvement Made Simple: What every board should know about healthcare quality improvement.*

West Yorkshire Police (May 2013) *Report on Operation Newgreen (West Yorkshire Police's review of its contact with Savile).*

List of trusts visited as part of the work

- Birmingham Children's Hospital NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust
- The Ipswich Hospital NHS Trust
- King's College Hospital NHS Foundation Trust
- Medway NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust

List of investigations into allegations relating to Jimmy Savile

The three main investigations

- Stoke Mandeville Hospital - Buckinghamshire Healthcare NHS Trust
- Leeds General Infirmary - Leeds Teaching Hospitals NHS Trust
- Broadmoor Hospital - West London Mental Health NHS Trust/Department of Health

Hospitals identified by the Metropolitan Police in December 2012

- St Catherine's Hospital - Wirral Community NHS Trust
- Saxondale Mental Health Hospital - Nottinghamshire Healthcare NHS Trust
- Rampton Hospital - Nottinghamshire Healthcare NHS Trust
- Portsmouth Royal Hospital - Portsmouth Hospitals NHS Trust
- Dewsbury and District Hospital - Mid Yorkshire Hospitals NHS Trust
- High Royds Psychiatric Hospital - Leeds and York Partnership NHS Foundation Trust
- Wheatfields Hospital - Sue Ryder
- Cardiff Royal Infirmary - Cardiff and Vale University Health Board
- Great Ormond Street - Great Ormond Street Hospital for Children NHS Foundation Trust
- Exeter Hospital - Royal Devon and Exeter NHS Foundation Trust
- Ashworth Hospital - Mersey Care NHS Trust

Hospitals identified by the Metropolitan Police at the end of 2013

- Barnet General Hospital - Barnet and Chase Farm Hospitals NHS Trust
- Booth Hall - Central Manchester University Hospitals NHS Foundation Trust
- De La Pole Hospital - Hull and East Yorkshire Hospitals Trust
- Dryburn Hospital - County Durham and Darlington NHS Foundation Trust
- Hammersmith Hospital - Imperial College Healthcare NHS Trust

- Leavesden Secure Mental Health Hospital - Hertfordshire Partnership University NHS Foundation Trust
- Marsden Hospital - Royal Marsden NHS Foundation Trust
- Maudsley Hospital - South London and Maudsley NHS Foundation Trust
- Odstock Hospital - Salisbury NHS Foundation Trust
- Prestwich Psychiatric Hospital - Greater Manchester West Mental Health NHS Foundation Trust
- Queen Victoria Hospital, East Grinstead - Queen Victoria Hospital NHS Foundation Trust
- Royal Free Hospital - Royal Free London NHS Foundation Trust
- Royal Victoria Infirmary - The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Queen Mary's Hospital - Epsom and St Helier University Hospitals NHS Trust
- Whitby Memorial Hospital - York Teaching Hospital NHS Foundation Trust
- Wythenshawe Hospital - University Hospital of South Manchester NHS Foundation Trust

Allegations received in 2014

- Woodhouse Eaves Children's Convalescent Homes - University Hospitals of Leicester NHS Trust
- Crawley Hospital - Sussex Community NHS Trust

Two hospitals identified by Leeds Teaching Hospitals Trust Savile investigation team

- Springfield Hospital - South West London and St George's Mental Health NHS Trust
- The Royal London Hospital - Barts Health NHS Trust

Discussion event attendees

- Dr Jackie Craissati MBE, clinical director, Oxleas NHS Foundation Trust
- David Derbyshire, director of practice improvement, Action for Children
- Donald Findlater, director of research and development, Lucy Faithfull Foundation
- Dr Peter Green, consultant in child safeguarding, NHS Wandsworth and St George's Hospital
- Shaun Kelly, safeguarding officer, Pearson
- Assistant Chief Constable Ian Pilling, Merseyside Police
- Steve Reeves, director of child safeguarding, Save The Children
- Detective Superintendent Paul Sanford, Norwich Constabulary
- Professor Richard Wortley, director, Jill Dando Institute