# Verita Newsletter Issue 24 – Spring 2015


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## Ed’s Welcome

The publication of the remainder of the Savile investigations and Kate Lampard’s lessons learnt report brings to a conclusion a major piece of investigative work in the NHS. When the Savile story broke in October 2012 few people would have imagined the scale of the task facing the health service. Over the last 2 and a half years, 44 NHS investigations have been completed to a high standard and, most importantly, in a manner sympathetic to the needs of Savile’s victims.

In addition to lessons learnt about keeping people in hospital safe this has also been a useful learning experience for trusts in the way that they carry out investigations, especially those in the public eye.

With best wishes

Ed Marsden
Managing partner

## Savile reports

In February Kate Lampard and Verita partner Ed Marsden published their lessons learnt report based on 44 NHS investigations into alleged abuse by Jimmy Savile.

Ed Marsden summarises the lessons: “NHS leaders have a key role in keeping people a safe part of the fabric of their organisation. Patients, visitors and staff should feel they can and should raise concerns when they have them. This is important today as although Savile may be history, the dangers people faced from him are still real and present.”

The report made 14 recommendations that included the need to have better monitoring systems in place for the NHS’s growing army of volunteers.

At the same time, 14 organisations published the results of their investigations into sightings of Savile and allegations against him in children’s homes and schools. An assurance report from Lucy Scott-Moncrieff, who was supported by Verita in overseeing the production of these 14 documents, was also published.

Lucy comments: “In many cases the findings were inconclusive but this reflects the passage of time since the alleged incidents took place, rather than any lack of thoroughness in the investigations. Many of the investigators recognise that the failure to make and retain records made it difficult to get to the truth and have made recommendations to ensure that these problems do not occur in future.”

Lucy’s lessons learnt report for the Department for Education will be published soon.

## Duty of candour

Verita has devised a diagnostic tool to help trusts quickly find out whether or not they are compliant with the CQC's duty of candour requirements.

The diagnostic assessment identifies areas of good practice and those requiring further development to comply with the legislation.

The duty of candour became statutory for secondary care providers in England in November 2014.

Trusts are now legally obliged to act in an open and transparent way in relation to care and treatment provided to patients. As soon as reasonably practicable after becoming aware that harm has occurred, trusts must notify the relevant person and provide support in relation to the incident.

The failure to comply constitutes a criminal offence and on conviction organisations could face a fine.

For more information about Verita's diagnostic assessment for duty of candour compliance please contact Chris Brougham on chrisbrougham@verita.net or 020 7494 5670.

## New serious incident diagnostic

Verita has built a serious incident diagnostic tool to enable trusts to identify strengths and weaknesses in their serious incident handling systems.

The tool offers providers a rapid method of assessing their performance against seven best practice standards: board recognition, system efficiency and quality, staff engagement, resources and infrastructure, the investigation, learning from serious incidents and involving patients and their families.

Verita's Chris Brougham explains: "Our tool gives trust the information they need to target problem areas, improve the quality of investigations, prevent backlogs and increase organisation-wide learning."

The process takes two days to complete, prompts discussion and requires limited preparation for staff taking part.

For more information please contact Chris Brougham on 020 7494 5670 or email chrisbrougham@verita.net.

## Misreporting of data

A London trust commissioned Verita to review its reporting against A&E and referral to treatment targets after it became aware of misreporting. The trust wanted to know the extent of the misreporting, why it had happened and what needed to be done to prevent it happening again.

Verita senior consultant Kieran Seale comments: “By interviewing over 50 clinicians and managers we were able to identify the cultural and performance issues lying behind the misreporting.

We are now working with the trust to give its board greater oversight of the issues underlying reporting and performance.”

## Patient safety fears

A group of commissioners approached Verita because of concerns about the safety of an inpatient mental health service. With consultation from Verita, the commissioners were able to gather the crucial information needed to implement an effective response and ensure patients were safe.

Senior consultant Geoff Brennan explains: “The clinical commissioning group was in a difficult position. It needed assurance that patients were safe but recognised there was a danger of making matters worse if the work was not handled sensitively. We had to design a process that would give good information not only for the commissioners but also for the service itself and not unduly alarm staff and service users.”.

Accompanied by Verita director Tariq Hussain, Geoff met with the commissioners, designed a template for collecting data and offered guidance on issues such as consent and patient confidentiality. The site work was completed within a week and the report was delivered in the following week to a risk summit. The template provided a structured approach for gathering intelligence from trust data, medical records, staff and service user accounts as well as analysing care and exposure to adverse incidents.

Geoff Brennan says: “We were able to provide information that has helped the service and the commissioners deliver better and safer care. Feedback from all parties involved, including staff and service users has been very positive. We are delighted that our template was so effective in a real live clinical situation.”

For more information on the assessment template, please contact Geoff Brennan on 020 7494 5670 or email geoffbrennan@verita.net.

## Select committee considers NHS investigations

Verita managing partner Ed Marsden gave evidence to a House of Commons Public Administration Select Committee inquiry in February. The inquiry is looking at the effectiveness of existing approaches to addressing safety issues in the NHS, models of best practice from other sectors and whether a new clinical accident investigation body for the health service should be set up.

Ed explains: “Our argument, based on over 13 years of experience in the field, is that any system of dealing with incidents in the NHS should be delivery and improvement focused, prompt, insightful and local. Independent investigations have an important role to play particularly when organisations are under scrutiny and need to satisfy the concerns of patients, the wider public and regulators.”

Helen Vernon, chief executive of the NHS Litigation Authority, professor Brian Toft of Coventry University and Michael Devlin of the Medical Defence Union gave evidence on the same day.

## A new approach to mental health investigations

Our initial use of ORA in a mental health homicide investigation will be in a trust in the north of England, commissioned by NHS England. We believe that this will signal a wider move from traditional investigation styles to a more innovative approach, bringing genuine insight and learning across all levels of organisations.

Over the 10 years that Verita has been conducting mental health homicide investigations, we have witnessed a change in attitude in the services under investigation.

Verita partner Peter Killwick explains: “In recent years, as trusts have become more used to the process and the statutory requirements of an investigation, while they are still taken appropriately seriously, there is a growing feeling of ‘business as usual’ with the findings recurring over several incidents and recommendations taking on a familiar feel. Trusts are suffering from investigation fatigue”.