Report of the external review of West London Mental Health NHS Trust’s Clinical Governance arrangements following the Jimmy Savile investigation

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1. INTRODUCTION

The purpose of the governance review was to assure the Trust Board, service users and their families, staff, commissioners and partners of the Trust that strong and effective systems of governance and safeguarding are in place across the Trust.

The review team reviewed progress in implementing the key quality, culture and safeguarding recommendations from the Jimmy Savile investigation report.

In addition, the review panel focussed on the Care Quality Commission criteria and assessed whether services are safe, effective, caring, responsive and well led.

2. PREFACE TO THE REPORT

The report outlines the findings and recommendations of the review team into the implementation of the key quality, culture and safeguarding recommendations from the Jimmy Savile investigation report, along with the systems of governance and safeguarding.

In choosing our approach to examining the quality, safety and culture of the organisation, we believed we could not do better than using the “Improving the Safety of Patients in England” report, often referred to as the Berwick Report as our benchmark and guide. The Berwick Report also embraced the key findings from the Francis Report.

To set the tone and focus for our review, we thought it sensible to remind readers at the beginning of our report the core mission statement from the Berwick Report.

“Place the quality of patient care, especially patient safety, above all other aims. Engage, empower and hear patients and carers at all times”.

“Foster whole heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work”.

“Embrace transparency unequivocally and everywhere, in the service of accountability, trust and the growth of knowledge”.

3. THE REVIEW TEAM CONSISTED OF:

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4. REVISED TERMS OF REFERENCE 9TH SEPTEMBER 2014

External Review of West London Mental Health NHS Trust’s Clinical Governance Arrangements.

The external review will report on:

4.1 Terms of Reference 1

A review of the Trust Board’s approach to quality. We will focus on the following recommendations from the Savile report which indicate the need to address culture:

- **Recommendation 5** – closed and introspective institutional culture discouraged physical and sexual abuse reporting and discouraged staff from taking action.
- **Recommendation 9** – Multiple sexual relationships between senior and junior staff and tolerance of relationships between staff and patients.

We will do this at Trust Board level by:

- Interviewing Trust Board members around culture issues.
- Interviewing non-executive Directors.
- Reviewing board members.
- Reviewing recent progress made.
- Reviewing internal and external assurance reports.
- Using CQC ‘well led’ prompts questions.

4.2 Terms of Reference 2

A review of Trust-wide safeguarding arrangements for both children and adults at risk including a review of current assurance processes regarding the effectiveness of such arrangements. We will focus on the following safeguarding recommendations in the Savile report:

- **Recommendation 1** – Review safeguarding processes within the organisation.
- **Recommendation 4** – Review procedures for safeguarding vulnerable people and how safeguarding theory is put into practice.

We will do this at Trust Board/Senior Local Authority level by:

- Meeting Executive Leads for safeguarding.
- Reviewing progress made regarding the separate LA responsibilities and the provision of social workers, which might lead to divided responsibilities.
- Reviewing risk assessment in relation to safeguarding structures and processes.
- Assessing the effectiveness of safeguarding partnerships.
- Examining learning as a result of safeguarding investigations.
4.3 Terms of Reference 3

A comprehensive review of quality governance systems and processes, paying particular attention to:

Reporting arrangements both within selected clinical service units and to the Trust Board. We will review the effectiveness of the systems and processes currently in place to ensure the dissemination and embedding of learning (across selected units within the Trust).

The effectiveness of the systems and processes in place to ensure early identification of areas where patient safety could be compromised.

We will review what we hear at Trust Board and Senior Management level about quality governance systems and processes by ‘testing’ our findings in three clinical services:

- Broadmoor Hospital (2 day review).
- Low secure services – Solaris Unit (1 day review).
- Older People’s Services – Jubilee Ward (including community service links) (1 day review).

We will do this by:

- Visiting local services and interviewing staff on site (MDT focus).
- Meeting with service users, family members and advocates.
- Meeting with commissioners.
- Reviewing reporting from ‘board to ward’.
- Reviewing the extent to which local quality data informs decision making.
- Testing the CQC ‘well led’ prompts from frontline staff.

We will prepare a narrative based report to be presented to the Trust Board in January 2015.

Our aims are to identify:

- Learning points or improving systems and services and developments in services since the Jimmy Savile report was published and any action taken by services since the report, including positive features of service.

To make:

- Realistic recommendations for action to address the learning points to improve systems and services.

To report:

- Findings and recommendations to staff, service users and the Trust’s partners.
5. APPROACH

Our principles were:

- To distinguish between fact and opinion / comment.
- To listen carefully to what was said.
- To be open, fair and objective as possible in our questioning, reasoning and conclusions.
- To avoid being biased by hindsight.
- To judge the care and treatment according to CQC criteria evidenced based practice or recognised positive professional standards and national guidance.

6. METHODOLOGY

We each read the report of the Jimmy Savile investigation, relevant policies, operational procedures and professional guidance and met to share our initial analysis and thinking and to identify other information requirements. We triangulated our collective issues of concern and positive practice.

We met with the Trust Chief Executive, Medical Director and Director of Governance and other senior management and clinical staff to refine and amend the Terms of Reference.

The extensive preparatory was helpful in enabling a comprehensive understanding of the organisational structure, systems, processes, attitudes and practice.

We then embarked on a programme of semi structured interviews with board executive directors and non-executive directors, senior management teams, a range of clinicians including, medical, nursing, psychology and other allied professionals, service users, governance teams. We also visited a number of wards and attended the patient’s forum at Broadmoor Hospital.

7. INTERVIEWS

The interviews were designed to clarify some of the potential concerns emerging from the various sources of information and for us to gather information and ideas from the interviewees own experiences, observations and insights.
8. SECTION 1 - CULTURE

Section 1 addresses the following Savile Report recommendations:

**Recommendation 5**
The closed and introspective institutional culture of Broadmoor failed to prevent some instances of psychological, physical and sexual abuse of patients and discouraged staff from reporting or taking effective action. We believe that the much needed improvement has been achieved, principally through recruitment, induction, training, continuing education and disciplinary policies. We recommend that the effectiveness of these policies continues to be monitored regularly by the Trust & the Care Quality Commission.

**Recommendation 9**
We believe that stories of multiple sexual relationships between senior and junior staff circulated widely within and outside Broadmoor, and were particularly corrosive. We believe that this contributed to an atmosphere that was unusually tolerant of sexual relationships between staff and patients in some parts of the hospital. We recommend that NHS boards ensure that policies and systems are in place to encourage staff to report such behaviour and make sure that the organisation can eradicate it.

**Terms of Reference**
A comprehensive review of quality governance systems to ensure the dissemination and embedding of learning (across selected units within the Trust).

This section reports on:

**Capability & Culture – Transparency, Quality & Safety Focus**
- Culture
- Organisation culture
- Leadership
- Leadership behaviours for safety
- Staff Engagement
- Visits to wards

**Capability & Culture - Learning & Development**
- Creating a culture for learning
- Good educational practice
- Clinical supervision
- Blame culture & escalating concerns
- Listening to staff & patients
- Evidence of a Learning Organisation
  - Learning lessons – Incident reporting
  - Learning lessons – SUI reporting
8.1 Capability & Culture – Transparency, Quality & Safety Focus

Well led question(s)
Does the Board shape an open, quality and safety focussed culture?

Introduction:
The JS investigation report highlighted the historical Broadmoor hospital culture as a major concern.

The report commented on the sexual mores in society at the time, the previous closed and institutional culture, where hostility was shown to those who questioned existing approaches or attempted to report concerns and the complexities of culture change.

Culture – Our understanding & definition
We thought it would be sensible to define and clarify our understanding of the term ‘culture’.

The dictionary definition:
“The customs and achievements of an organisation” “Conditions suitable for growth”.

The Berwick Report (2013) makes numerous specific references to the importance of culture. “in the end culture will trump rules, standards and control strategies every single time and achieving a vastly safer NHS will depend far more on major cultural change than a new regulatory regime”.

Specific concerns from the past included a ‘custom and practice orientated’ and a closed and introspective culture which:

- Emphasised control rather than care.
- Tolerated inappropriate attitudes and behaviours and discouraged reporting of concerns.
- The absence of written policy guidance and procedures and where they were present, not always observed.
- Was reluctant to change traditional inward thinking.
- Service users were perceived as criminals, not valued and described by some staff members in pejorative terms.

The Savile investigators commented on the considerable progress achieved at Broadmoor, in particular, that current policies, procedures and practices were likely to minimise the sort of abuse which had occurred in the past. However, the report indicated that policy and guidance could not guarantee this and that more needs to be done, particularly in greater candour and transparency.

The authors of the Savile investigation insightfully recognised that changing the attitudes and practice within an institution takes time.
8.2 Findings, analysis and suggestions

We recognise that there is no quick fix to change organisational culture, it is a long haul which requires a constant focus and continual action to sustain further improvements.

This external governance review coincided with the contentious proposals for withdrawal of special financial leads for bank nurses and new starters resulting in a high degree of staff dissatisfaction. We also heard of recent difficulties with recruitment across WLMHT due to out-sourcing of certain HR services. This resulted in delays in filling vacant posts and staff feeling devalued and overstretched. This clearly influenced the morale, perspectives and views of many staff we interviewed.

The resulting significant reduction in numbers and skill mix during this period led to difficulties on occasions in providing the necessary cover to ensure patient activities were consistently maintained. This situation led to staff and service users feeling frustrated and disenchanted.

We were informed of improvements that are slowly resolving the recruitment difficulties and have seen reports indicating that the staffing difficulties encountered in the summer have been largely resolved. We understand that in March each year, a skill mix review is undertaken and then benchmarked with other high secure hospitals.

We suggest that the outcome of the March review should be considered not only by the Senior Management Team, but by the Trust board to confirm that the improvements have been sustained.

Organisational Culture

We give below a summary of our specific findings including positive aspects and areas for improvement.

We were informed that the Trust board were taking cultural change seriously and the chief executive was personally leading and coordinating initiatives.

The disappointing national staff survey results (2013), especially the low scoring on bullying and harassment were of particular concern to the board. We acknowledge that amongst a substantial number of staff there will be different experiences, perceptions and opinions.

We recognise that in addition to current genuine expressions of concern and frustrations asserted by staff, some longstanding disenchanted staff and others who have ‘personal axes to grind’ may ventilate their frustrations through the staff survey and other media.

It would be wrong however, to dismiss all concerns raised as being solely the result of a minority of staff with long-term negative attitudes. Sustained and constructive efforts to counter negative thinking and behaviours are required to prevent those who are disenchanted from influencing others.

During our review, we have noted many strategic plans to promote change and to genuinely improve staff engagement. We have heard positive accounts of the engagement initiatives underway. These early optimistic indicators are likely to flourish with consistent approaches to staff engagement, sharing the Trust's values with strong but sensitive leadership.
Leadership

During our discussion around ways in which the staff survey findings might be improved, we were informed of a range of impressive leadership initiatives and plans including:

- A leadership development strategy which has refreshed the vision and includes succession planning and skills development.
- A leadership programme with a Multi-Disciplinary Team focus aimed at Bands 5 – 8 with an emphasis on change management. All managers attending this programme complete a staff engagement project.
- A 360 degree feedback exercise has been started at Broadmoor, where teams in poorly performing services assess their manager. This is in response to national staff survey results, and with input from the quarterly leadership forum to address a disconnect between frontline staff and some middle managers.
- A review of the Trust’s appraisal system to improve quality and uptake of appraisals.
- Training for managers in completing appraisals.
- The development of a BME leadership development programme to increase opportunities for and numbers of BME leaders.
- A leadership model has been agreed for Allied Health Professionals, social workers and psychologists aimed at improving leadership effectiveness and morale.
- HR surgeries for managers are being piloted.
- Monitoring of the Back to the Floor project.
- Seeking views of staff for preferred methods of communications to improve engagement.

We formed a very positive view of the many board and service initiatives currently underway to address the concerns and develop the organisational culture. It is clear that there has been significant investment in a range of staff engagement activities, with the chief executive leading and co-ordinating many of the initiatives. We observed his high level of commitment and enthusiasm, visits to services and use of his personality to good effect.

Many of the initiatives are still regarded as work in progress and the effectiveness and benefits have yet to be determined. Staff surveys and other routes for feedback will be indicators of success or otherwise.

Many of the areas for improvement that we have identified are already known and the range of specific initiatives mentioned above is designed to manage these concerns. However we consider that a number of existing managers and clinical leaders will need to be further challenged and supported to become more self-aware so as to better lead and inspire their teams.

In addition to the current leadership initiatives we strongly suggest personalised development strategies to help them acquire the necessary understanding of their roles/responsibilities, so that they can align themselves with Trust’s vision and values.

All staff should be encouraged and supported through appraisals, job planning and professional development activities to make their contribution to the Trust’s objectives and be held accountable for their performance.
Broadmoor

We heard that at Broadmoor ‘there are a lot of managers but not many leaders’.

It was suggested to us on a number of occasions that at Broadmoor there was:

- An absence of dynamic and progressive leadership, skills and commitment amongst a number of middle managers and some senior clinical staff.
- A sense of change fatigue amongst many staff, who perceive endless imposed change without understanding why or being involved or having ownership.
- A number of staff who have historically been disillusioned and as a consequence have lost their motivation and drive.
- A lack of aspiration and ambition amongst some staff, who are content to accept mediocrity or “be no less than other services”, rather than striving to be the best.
- An assumption on the part of some managers and clinicians that effective leadership, communication and motivation of staff and dealing with poor performance and practice is the responsibility of the board and senior management.

Meeting with the Medical Consultants at Broadmoor

The consultant medical group appeared somewhat demoralised and gave the clear impression that they felt unappreciated and peripheral to the many management initiatives. They gave examples of how their suggestions for service developments and improved efficiencies had been ignored, whilst there had been no strategic investment in their development. Further, they described the service as being ‘nurse led’, and that they were only valued for their RC (Responsible Clinician – a legal Mental Health Act function) role.

Whilst the views expressed by the consultants are clearly subjective, and there was some evidence to contradict some of their beliefs, their collective views are important and need to be addressed as a matter of urgency.

We discussed this with the new Clinical Director for Broadmoor who was already aware of the issues, and was already working on a number of development options.

Leadership behaviours that reduce risk and make health care safe:

The Berwick report (2013) makes fundamental suggestions around setting and measuring personal and service standards and goals. These could be used in supervision, IPR, coaching sessions and we therefore recommend that these are seen as priority content for leadership programmes. They include:

- Abandon blame as a tool.
- Constantly and consistently assert the primacy of safely meeting patients and carers needs.
- Expect and insist upon transparency, welcoming warnings of problems.
- Recognise that the most valuable information is about risks and things that have gone wrong.
- Hear the patient voice, at every level, even when the voice is a whisper.
- Seek out and listen to colleagues and staff.
- Expect and achieve co-operation without exception.
- Give help to learn, master and apply modern improvement methods.
- Use data accurately, even where uncomfortable to support healthcare and continual improvement.
- Lead by example, through commitment, encouragement, compassion and a learning approach.
- Maintain a clear, mature and open dialogue about risk.
- Infuse pride and joy in work.
- Help develop the leadership pipeline by providing support and work experience to enable others to improve their own leadership capacity.
- Recognise that some problems require technical action, but that others are complex and may require many innovative solutions involving all who have a stake in the problem.

### Staff engagement and participation

The Trust has developed a comprehensive staff engagement plan and established a staff engagement committee.

The engagement plan has four overarching workstreams and progress is monitored quarterly against milestones with RAG ratings. Progress is discussed at staff engagement committee meetings. Following each committee meeting, a newsletter, “Action for Change” is widely distributed and updates are provided for the weekly ‘Monday Matters’ meeting.

The Trust has a range of engagement recognition and culture initiatives which include:

- A ‘culture and behaviours’ statement written by specially recruited staff.
- New staff are interviewed after six months to obtain their initial insights and views.
- Back to the floor initiative at Broadmoor, where senior staff work a shift in a service, to be visible and gain a better understanding of frontline service pressures.
- A programme of non-executive and executives visits.
- Monthly listening exercises held in various settings/services.
- ‘Speak up Friday’, which enables staff to speak to non-executive directors and the chief executive.
- Employee of the month and annual staff recognition awards.
- Various staff satisfaction surveys.
- The innovative ‘fishbowl’ initiative. This involves recruitment of ‘30 volunteer staff reporters’ who each enlist 10 members of staff to provide Board feedback in a ‘fishbowl’ exercise.
- Recruitment and selection policy actions to create equal access to career progression and promotions.
- Work on reduction in bullying and harassment across the organisation, including befriender schemes, review of dignity at work policy and specific focus groups.
- Review of Whistleblowing policy.

We noted initiatives inviting direct communications with the chief executive and directors. We consider further work be undertaken to replicate this at senior management level. We consider this might invigorate their own listening to and responsive communication arrangements. Some staff may be inhibited about contacting the chief executive directly and may prefer to raise matters with more local managers if they are encouraged to do so.
It is advocated from positive practice elsewhere, that those who do contact senior managers should receive an acknowledgement within 24 hours and their ideas considered within seven days or sooner, depending on the particular issues.

8.3 Reflections and conclusion

Whilst noting significant progress in culture change, further refinement and developments are necessary for continuous growth in attitude, awareness, ideas and practice.

Despite an impressive range of strategies, staff engagement and leadership initiatives and tangible commitment, we sensed a frustration that the hoped for change in thinking, behaviours and performance was not embedded as rapidly as originally envisaged.

The energy, resource and time devoted to these staff engagement activities are commendable and it may appear somewhat churlish to be critical, which we are not. However, we recommend the regular review, monitoring and evaluation of the various initiatives.

Our reservation is based around the possibility of executive management being too eager and over ambitious in the Trust’s desire and determination to change in a short period of time. We note the potential for overwhelming staff and we heard of initiative fatigue and a feeling that some of the initiatives had not had the necessary time, resource and evaluation to succeed and be sustained.

It needs to be considered whether the many impressive actions are sufficiently penetrating for the hard to convert or those with deep rooted grievances, or is this an instance of preaching to the converted?.. Do such initiatives get below the surface and reach those who are not signed up to the Trust’s vision and national strategies and policies?

We consider that nurturing talents, engendering trust, building confidence and resilience, bringing about collective leadership at every level is critical and further work in these areas is necessary.

The emphasis on collective leadership is key, creating the right conditions for openness and continuous learning. In turn this is likely to bring confidence and credibility leading to better results and improved patient outcomes.

Leaders within the Trust, at all levels will need to further drive the culture change and development. They should be exemplars with appropriate behaviours that should epitomise the Trust’s values and philosophy.

Managers and leaders must be relentless, perhaps in campaigning mode, in their determination to achieve the desired improvements and be imaginative, empathetic and creative in their efforts to engage and convince staff of the need for change.

We were impressed with the 360 degree feedback concept. It appears that some middle managers are more effective than others in staff engagement and staff support. They may require individual development strategies to increase their awareness, skills and capability.

We consider this is an imaginative and bold initiative, which is aimed at a specific tier of managers, some of whom it appears do not always fulfil the responsibilities expected of
them. We acknowledge this initiative may cause resentment and anxiety and needs to be handled sensitively but we recommend that this is implemented so as not to lose momentum within the leadership plans.

Key to culture change will be the perception that managers and leaders are genuinely listening and are open to the concerns of staff. Staff need to feel valued, feel that they have a voice and that it is safe to report concerns.

Evidence suggests that engaging with employees leads to improved performance, optimism and loyalty. Effective engagement requires trust between management and staff. High trust organisations are better able to attract and retain quality staff, have greater motivation and commitment and lower absenteeism. This in turn leads to improved services and patient care and a sense of enjoyment and pride in what they do.

The best organisations empower their staff to speak up and have a dissenting voice if they have concerns or see the need for improvement. People are more likely to speak up in a healthy working environment where there is mutual respect between senior management and professional staff.

We consider that in some instances trust will have to be created and further developed. To facilitate the reporting of concerns, we suggest that within clinical supervision, everyone should be encouraged to speak up as a matter of course and be reminded of their duty of care responsibilities and the recent duty of candour requirement.

Evidence also shows that successful organisations look after the health and wellbeing of staff which in turn can have a positive effect on patient safety and experience. Managers should ensure there are sensible and practical approaches to the health and wellbeing of the workforce as a balance to the on organisational performance.

Of note, evidence from research demonstrates that the highest performing organisations have specific cultural characteristics, which help to create positive conditions associated with learning, innovation and improvement.

These characteristics are:

- Inspiring vision and compelling narrative.
- Clear objectives at every level – board to frontline.
- Supportive people and management.
- High levels of staff engagement.
- Learning and innovation being the responsibility of all.
- High levels of team working and co-operation across boundaries.
- A holistic approach to staff health.
- Understanding causes of stress.
- Supporting staff with workload, financial worries, work or family problems.

We recognise that there are a significant number of leadership initiatives already underway, but we consider that there could be considerable benefit in continuing to evaluate initiatives, refreshing current thinking and strengthening some approaches.
We understand there is a capacity limit to what can be done at any one time and there is a problem of having initiative overload, therefore activities need to be sequentially planned and co-ordinated. However, we consider that the challenge is to be even more creative in the use of time and considering how to motivate and release staff to participate.

Cultural change processes need to be prioritised, reviewed at intervals, not be overly bureaucratic or time consuming. They should not distract from essential care and treatment processes, which would tarnish the philosophy and purpose and bring the development initiatives into disrepute.

8.4 Recommendations

We make the following recommendations:

Culture
Sustained and constructive efforts to counter negative thinking and behaviours are required to prevent those who are disenchanted from undermining others.

That the senior management team continue to monitor cancelled patient activity and the effect on staff and patient morale.

Ensure that appropriate plans are in place to provide ample cover during known holiday periods such as August.

We suggest that the outcome of the March (peer group) benchmarking exercise with the other high secure hospitals review should be considered not only by the Senior Management Team, but by the Trust board to confirm that the positive changes have been appropriate and have been sustained.

Leadership
We recommend that the Trust evaluates the current range of leadership initiatives and then develops a plan with reference to the Berwick leadership behaviours, to bring greater cohesion and focus to preparing/equipping managers and clinical leaders to fulfil their leadership responsibilities.

We recommend that the management proposed 360 degree exercise is implemented so as not to lose momentum within the leadership plans.

The senior management team should address the issues raised by the consultant medical group who appeared somewhat demoralised and gave the clear impression that they felt unappreciated and peripheral to the many management initiatives.

There should be personalised development strategies to help staff acquire the necessary understanding of the full extent of their roles, so that they can identify with and be committed to the Trust’s vision and objectives and be accountable.

Staff engagement
We would recommend that initiatives inviting direct communications with the chief executive and directors be further strengthened at senior management level.
Sharing Positive Practice Examples
We have gathered some ideas and positive practice examples from other services as well as from our own experiences and include them as:

Appendix 1 - Development and enhancement of organisational culture
Appendix 2 - The implications of a negative culture
Appendix 3 - The features of a positive culture to assist understanding, stimulate change and further development.

We hope these will be of value in achieving the above recommendations.

8.5 Capability & Culture – Learning & Development

Well led question(s)
Does the Board support continuous learning and development?
Is there evidence of the dissemination and embedding of lessons learnt?

Introduction (context) what we would expect to find:
A culture of customised and collaborative learning through training, professional development and clinical supervision is essential for the creation of a motivated and inspired workforce, who are committed to deliver safe services and consistently look to make improvements.

A summary is provided to aid awareness and underscore the benefits and characteristics of a learning organisation:

“a learning organisation culture is one which relishes curiosity, questions and ideas, which allows space for experiment and reflection, which forgives mistakes and promotes self-confidence” (Hardy).

The Berwick Report (2013) further remarked that the benefit of a learning organisation will be the reduction in patient harm. The report advises that services should:

- Embrace an ethic of learning: mastery of quality and patient safety sciences and practice should be part of initial preparation for practice.
- Ensure lifelong learning of all healthcare professionals, including managers and executives.
- The NHS should be a learning organisation it’s leaders should create and support the capability of learning.

The challenge for the Trust is to further develop an ethos of continuous learning, assessing evidence upon which care is based and to ensure staff are exposed to the latest developments and up to date practice nationally and internationally. This is especially important in more closed environments where it is difficult to release staff.
Creating the culture for learning

Training and development is likely to lead to improved staff knowledge, confidence and a greater willingness to be responsive to change, to be open and to accept challenge.

Skills and knowledge development are essential for staff to have the confidence to report concerns, to prevent and manage patient safety incidents and avoid unnecessary complaints.

A service which invests in a learning culture will attract new recruits, improve knowledge and skills and enhance the reputation and morale of clinical practitioners. It is more likely to achieve innovative practice translated into daily dealings and effective teamwork, this includes embedded reflective practice.

During our visit to Broadmoor we heard of structured reflective practice sessions which staff told us were a key aspect of discussing personal and professional relationships and were key to understanding and managing the boundaries between relationships. This allowed for staff to discuss their own vulnerabilities as well as those of their patients and was seen to be a cornerstone of excellent professional practice.

Good educational practice

Our discussions with trainees both at Broadmoor and in low secure services provided some assurance of a positive learning environment for trainees. We heard that nursing and medical trainees had structured training programmes and we were advised that the evaluation of the Broadmoor student nurse placement is very popular and often results in recruitment to the Broadmoor services after qualification.

The psychology trainee was particularly appreciative of the range of learning opportunities available to her and the support she had received from supervisors and colleagues.

We questioned staff about on-going professional development opportunities and were informed that an active programme is in place but that sometimes staff can’t attend sessions on the Broadmoor site due to travel difficulties.

We noted the development of a number of professional development initiatives, some recent examples are given below:

- Restorative justice.
- Medicines safety.
- Programme for carers - The Trust has continued to develop their support for carers at Broadmoor which is facilitated and led by the social work department. The course is designed to equip carers with additional coping skills.

We were informed of improvements in the numbers of staff attending mandatory training and in particular the number of staff attending safeguarding training.

During our clinical site visits we asked staff for examples of staff presenting at conferences, winning innovation awards, having articles published in peer reviewed journals but found few, if any examples. We have since been informed of publications by clinicians in forensic services and an active forensic clinical research domain. We recommend that all staff are stimulated to network, conference and publish as we have seen some excellent initiatives.
during our visits. We heard of healthy and well established relationships with local universities which we suggest could develop further into research learning sets and writing partnerships.

Clinical Supervision
The majority of staff we spoke to were receiving clinical supervision and understood its importance to mental health practice. We were made aware of a new training programme, designed for both supervisors and supervisees with improved guidelines. We also understand that a new measure of auditing the uptake and standards of supervision is shortly to be implemented.

We strongly support efforts within the Nursing Strategy to strengthen clinical supervision and urge that time and resources for supervision are available.

We suggest a further focus should be given to the benefits of group supervision and reflective practice for all frontline staff, to support practice development.

Blame culture and escalating concerns
It is our belief that a culture that invests in education and lifelong learning for all staff, will help promote professional and caring values that better prepare staff when working with extremely vulnerable service users.

Encouraging staff to understand all aspects of their caring and professional roles, to act with respect towards service users and each other and to routinely question each others’ practice will provide a more open and collaborative care approach. Demonstration of organisational values through day to day interactions should be commonplace especially from the leaders of services.

We found no evidence or suggestion that people were victimised or side lined as a result of raising concerns, in fact we heard examples that suggested the opposite and we were told repeatedly that accountabilities are now much stronger than at the time of the Savile report.

However, we heard some perceptions from a small number of staff that a blame culture is still present in parts of the service. This is reflected in the 2013 national staff survey results and indicates the need for further and consistent work around providing the culture in which staff can feel safe to raise concerns across all services within the Trust, free from repercussions.

We commend the analysis of the national staff survey report and the subsequent staff engagement work that is in place. The introduction of other measures alongside the national staff survey are recommended to constantly ‘temperature check’ staff confidence around raising concerns.

Whistleblowing
Overall, we heard that staff knew how to and felt able to escalate concerns. Most staff felt that to ‘whistleblow’ was extreme and that they would try to reconcile differences before using the escalation of whistleblowing procedures.

We heard of two specific examples where staff had reported a concern directly to their line manager with the effect of appropriate and proportionate action being taken. Staff had felt
supported and felt that thorough investigations had taken place. In one service we heard that ‘this would not have happened previously’. Staff felt that they had been ‘listened to’ by their executive director.

Listening to staff and patients
At Broadmoor we met with a range of trainees, both medical and psychology. We valued their objective and fresh insights. They were fulsome in their praise of the service. They did not raise any serious concerns and made positive comparisons with other services they had experienced.

They reassured us they that they had not observed any “blanket rules”, which were routinely overly restrictive. They remarked that the opposite happens, with nurses going to extra lengths to meet the needs of patients and proactively avoid conflict.

They reported that the care and treatment was “the best seen in their experience to date, with patients being valued and respected”. They shared a number of positive examples of care delivery in difficult circumstances. However we heard from all of the trainees that they would like to see improvements in more contact time with patients.

They also commented on the negative implication of the prevailing staff shortages and the concern regarding the loss of financial enhancements affecting staff morale. However, they positively commented on the actions of staff to support each other and “make the best of it”.

They considered that some patient care activities are compromised due to the lowered number of staff available. They urged for patients to have more time out of their rooms.

They felt they benefited from the levels of support and supervision available but commented that bank staff do not receive clinical supervision or reflective practice opportunities.

The Senior Nurse Tutor responsible for student nurse placements at Broadmoor spoke of the regular positive feedback from nursing students. He indicated that a significant number went on to apply to the hospital following qualification. He also commented on the improvements in attitudes and patient care that he had observed over time.

We were also reassured by the comments of the team of independent advocates, who described how they functioned and provided a voice for patients in different settings and informed them of different options in pursuing their rights and needs.

Their overall view was that considerable change and improvement had occurred over the past ten years. They gave examples of positive practice incidents. They considered that most staff understood their function and viewed the advocacy service as positive and now called upon the advocacy service for clients likely to benefit. They consider the link to the Recovery College is a very positive one.

They believed that appropriate steps were taken to enable the spiritual and cultural needs of service users to be met and provided examples of how specific dietary and religious clothing needs had been met by staff.

We were further reassured by the advocates’ explanation of how they maintain their own independence and objectivity and avoiding familiarisation with employed staff. The
advocates consider the working environment has improved and do not feel unsafe. They are confident that staff would appropriately intervene and help with potential altercations.

Visits to wards

We selected a small number of wards to visit at Broadmoor, which gave us the opportunity first hand to observe and experience the environment and ambience.

On our visit to Sandown Ward, we noted that attempts had been made to create a peaceful and relaxing atmosphere with the application of the innovative “Safeward” approaches, developed by Professor Len Bowers to reduce conflict and incidents.

We observed positive practice in encouraging a patient to leave his room where he had confined himself for a long period of time and to walk out into the garden. For safety purposes, six staff were involved in escorting him. The service user was clearly making good progress and he was evidently proud of his achievements to date.

We also noted art work and an example of a recovery tree which had been created by staff and patients working together, which enhanced the environment.

We understood that the Mental Health Act Commission had identified concerns in respect of feeding a patient through a door hatch, which had now stopped.

We further visited Solaris Ward in the low secure services, where we observed a disruptive and violent outburst, which we assessed was dealt with appropriately and effectively. Staff were trying hard to create an open and respectful culture despite working in a very outdated physical environment. We were impressed with the enthusiasm and motivation of the senior staff to make improvements for service users.

We saw evidence from staff and community meeting notes that incidents and patient concerns are discussed regularly and we saw the quality board which detailed improvements that had been made in response to the weekly patient experience survey.

We also visited Jubilee Ward in the Older People’s services, which is part of the very old hospital estate which felt tired and rather institutionalised. We observed there was no quality board on display and were told that there was a delay in having it installed.

The Broadmoor Patient’s Forum

Listening to patients and acting on feedback is key to improving the ‘lived’ experience for patients and service users.

The chair of our review team attended the monthly Patient’s Forum and was impressed with a number of positive features. These include:

- Joint chairing by a senior nurse and a patient.
- Attendance by patients representing each ward, who brought a list of issues from their fellow patients.
- A substantial number of senior staff from the various services including estates, security, advocates, clergy, senior and middle management and clinical leads, catering and clinical staff from all wards.
• Professional minute taking, and progress on action points being discussed at subsequent meetings. Those responsible for progressing the action will be held to account.

Concerns raised included access to computer games, meals and TV access. Also, a number of service users expressed concerns that recent shortfalls in staffing had negatively impacted on opportunities for recreational activities.

• A patient complained he had been assaulted by another patient on Newmarket Ward. Following this incident we checked that this incident had been reported through the safeguarding routes and we were assured that this had been done.
• A further concern raised by a patient representative was the inadequacy of access and time spent with his consultant psychiatrist.
• Of note, a patient representative complimented the security team for the way they had intervened the previous weekend when there was an excessive number of visitors. It appears that other accommodation was speedily made available and refreshments provided.
• Also in attendance were Bill Kirkup and Paul Marshall, the authors of the Jimmy Savile report, who described the outcome of their investigation and responded to questions.

The meeting was well led and managed and we are confident that if a patient had concerns in respect of their care and treatment or if there were other organisational issue, they would be able to bring them to the Patient’s Forum. The open nature of the meeting and the monitoring of action agreed is an additional authentic safeguard, and we consider the Patient Forum is a notable development.

The review team were invited to return to feedback the main points arising from this review.

The Broadmoor Users and Carers Group
We attended the Broadmoor Users and Carers group which was chaired by a service user. The purpose of this recently established group is to explore in more detail clinical and quality issues, some of which may have been raised at the Patient’s Forum.

We were impressed with the range of the membership and the joint chairmanship of a service user and senior nurse. We were also impressed with the positive nature of the discussion. We understand that the function and effectiveness of the group is to be evaluated shortly. We consider this to be a further positive development in terms of increasing the voice and influence of the service users which demonstrates a real shift towards an open and a ‘listening’ culture.

Evidence of a learning organisation
Learning the lessons – SUI investigations
The Medical Director has the overall responsibility for the management of serious incidents within the Trust and the cascading of any lessons learnt from it. The Incidents Reporting and Management Policy describes the arrangements for effective Serious Incident reporting, management and investigation within the Trust so that opportunities for learning are identified and changes in practice result.
The Trust commissioned an internal audit of lessons learnt from SUI reviews and never events in October 2014 which gave a judgement of reasonable assurance. The internal audit report states that:

The Trust board meets monthly and discussions at part 2 of the board meetings include grade 2 Serious Incidents. This allows board members as well as the management team to capture and circulate lessons learned among staff to close any gaps and avoid the same incident recurring in another location within the Trust.

Review of the board minutes showed that serious incidents are reported within the integrated performance reports as a patient quality/safety indicator. The lesson learnt from serious incidents is discussed in each paper. The July 2014 board paper details workshops being held to address a change with lessons learnt from serious incidents and developing elements of a safety culture.

Learning that comes from the serious incident investigations should be shared with staff via ‘The Week’, Monday Matters, Medical Directors Bulletin and the Mental Health Matters. This will ensure that staff are aware of lessons that need to be learnt following a serious incident and may prevent similar incidents occurring.

In addition to the various newsletters, lessons learned from serious incidents are shared with staff within the Trust via the Central Alerting System Tracker (CAST) and the Internal Safety Alert by the governance department.

We were interested to talk to clinical staff to hear their accounts of how lessons are learnt within the Trust. From our visit to Solaris ward, we were told that learning from incidents and complaints is shared by:

- Monthly CIG meetings.
- Notes in staff book available to all staff (we were shown example of this).
- Staff attend a six monthly Trust-wide learning the lessons event, usually attended by over 100 staff.
- Trust-wide circulation of laminated sheets with action points.

We saw laminated sheets with lessons learnt which are directly distributed to clinical areas.

Staff were able to give us examples of changes to practice as a result of lessons learnt.

We heard at a later meeting with the governance staff that incident reporting ‘stays at CSU level and the optimising of learning and wider sharing of lessons learnt is not always followed through’. We suggest these concerns need some attention.

**Positive findings**

- Learning lessons events are held at CSU level and at Trust-wide level.
- Several communications are used to share lessons learnt with staff including Bulletins are used.
- The Week’, Monday Matters, Medical Directors Bulletin and the Mental Health Matters.
- Laminated ‘lessons learnt’ sheets.
- Development of a single team agenda for consistent reporting of quality issues.
RCA training for investigators.

8.6   Findings, analysis and suggestions

We give below our findings and impressions:

We felt it important to seek as many external sources of assurance as possible during our brief review, to ensure that an external perspective of culture and practice informed our review. We were keen to meet with service users and patients directly to hear their experiences first hand.

Our meeting with the various trainees provided significant evidence of good practice and of well established, supportive learning environments. We were pleased to hear that the students had not observed any overly restrictive practice or witnessed application of 'blanket rules'. We were heartened by their accounts of staff going the 'extra mile'.

The ward and community visits provided opportunities to assess care practices and attitudes. We witnessed appropriate care and met staff who were welcoming, open and enthusiastic.

The Broadmoor Patient Forum and Service User meeting are transforming the ways in which patients are listened to and we felt privileged to be welcomed to both meetings.

We found no direct evidence of a blame culture. Staff we spoke to were knowledgeable about the concerns and escalation polices and did not feel inhibited in their use.

We note the on-going progress since the publication of the Savile report and hope that our recommendations might stimulate further improvement.

Positive practice

The following list identifies positive practice to ways to continue to ‘open up’ culture and expose staff to new learning experiences:

- Actively seek secondments and shadowing both within the organisation and with external key stakeholders.
- The benefits to the individual and the organisation of networking should be promoted, to enable connections, sharing of ideas, make comparisons, change thinking, development of knowledge, influencing and problem solving skills, to enhance motivation and access to positive practice strategies.
- Twinning with other Services to exchange information, protocols, visits and placements.
- Promote and support application for scholarships.
- Promote the benefits of mentorship and facilitate opportunities for coaching at all levels.
- Develop improvement collaboratives to take forward local quality improvement and encourage local problem solving.
- Set out to win innovation awards.
- Staff to be encouraged to attend Board meetings and other important decision making forums.
- Engagement in learning sets.
• Consider the appointment of safety and other key themed ‘fellows’ to enable staff to further develop specific areas of expertise.

• Devote one or two sessions a week to work on key project development work with teams, following incidents in order to facilitate learning and deepen their understanding.

• Invite patients and carers to share their experiences on camera. It lets them know they are valued and can be powerfully used for training and professional development purposes.

• Provide opportunities to chair/lead meetings/projects or write a strategy or training initiative or be a member of an SUI panel.

We consider that there would be value in facilitating learning and sharing across diverse services and different professions, with the extra benefits of being exposed to different perceptions and skills.

A table outlining the characteristics of a learning organisation are included in Appendix 5.

8.7 Recommendations

Creating a culture for learning

We would recommend that staff are encouraged to network, conference and publish as we have seen some excellent initiatives during our visits. We heard of healthy and well established relationships with local universities which we suggest could develop further into research and writing partnerships.

We encourage managers and staff to move from ‘the middle ground’ and aspire to be the best.

Clinical supervision

Clinical supervision is personalised to meet the different individual needs of staff who have different levels of skills and experience and monitored during managerial supervision.

Consider ways in which bank (and where appropriate) agency staff might benefit from clinical supervision or reflective practice opportunities.

The Trust should actively display the standards for clinical supervision and monitor the uptake across different services.

We strongly support efforts within the Nursing Strategy to strengthen clinical supervision and urge that time and resources for supervision are available.

Blame culture & escalating concerns

Consider wider measures alongside the national staff survey findings to constantly ‘temperature check’ staff confidence with raising concerns.

Evidence of a Learning Organisation

To evaluate the impact of training programmes on subsequent service provision.
We urge consideration be given to ways in which the positive practice ideas might be implemented.

We heard from governance staff that incident reporting ‘stays at CSU level and the optimising of learning and wider sharing of lessons learnt is not always followed through’. We recommend these concerns are addressed.

We urge that managers be encouraged and given the opportunity to actively participate in incident reviews to share knowledge across CSUs and the wider Trust.
9. SECTION 2 – REVIEW OF GOVERNANCE

Section 2 addresses the following Savile report recommendations:

**Recommendation 5**
The closed and introspective institutional culture of Broadmoor failed to prevent some instances of psychological, physical and sexual abuse of patients and discouraged staff from reporting or taking effective action. We believe that the much needed improvement has been achieved, principally through recruitment, induction, training, continuing education and disciplinary policies. **We recommend that the effectiveness of these policies continues to be monitored regularly by the Trust & the Care Quality Commission.**

**Terms of Reference 3**
A comprehensive review of quality governance systems and processes paying particular attention to:

- Reporting arrangements both within selected clinical service units and to the Trust Board.

This section reports on our governance review under the following headings:

**Strategy & Planning**
- Quality strategy
- Creating the culture for quality improvement
- Role of the Board in Implementing Strategy & Board Development
- The Board member visiting programme

**Board Governance – structures and processes**
- Governance structure
- Governance reporting at CSU level
- Proposals for a new Trust-wide governance reporting structure
- Seeded out governance arrangements
- Quality Accounts

**Measurement & Performance reporting**
- Trust Board Integrated Performance Report
- Measurement – Quality & Safety data at board level
- Measurement - Quality & Safety data at CSU and team level
- The Heatmap
- Early warning indicators
- Quality Improvement
- Local visual display of Quality & safety data

**Risk Management**
- Risk management at CSU level
- Risk management and corporate governance
• CIP and risk assessment

9.1 Strategy & Planning

Well led question(s)

Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

Are accountabilities for governance clear?

Are there clear structures for ‘Ward to Board’ governance reporting?

Introduction (context) what we would expect to find:

At the outset of our governance review we would expect to find a Quality Strategy that demonstrates a strong commitment to the following:

The six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour (Hard Truths, the Government’s Response to the Francis Report, 2014).

A well written and comprehensive Quality Strategy which sets the quality direction and vision and provides clear Trust-wide objectives which are made known to staff. This would link with and provide context for the Trust annual Quality Account.

That the board has developed its Quality Improvement Strategy through the development of systematic processes for engaging staff in its development, communication and selected indicators (Monitor Well Led Governance Framework, 2014).

The Quality Strategy would include clear Trust-wide governance structures for its implementation and monitoring of its achievement.

Frontline staff would know the key strategic quality objectives and would be engaged and supported in achieving and monitoring them.

The processes adopted for this review of governance includes: The Trust’s Quality Strategy - The ‘Quality Strategy 2013-18 – Our pathway to Excellence’ which provides the 5 year plan for quality improvement at West London Mental Health NHS Trust. (WLMHT). We further reviewed other strategic quality documents and reports, then discussed the strategic quality aims and supporting processes during our various meetings with board members, staff, service users and patients.

9.2 Findings, analysis and suggestions

The Quality Strategy is a refresh of the previous 2011 Quality Strategy and is based on the Darzi quality definition of patient safety, patient experience and clinical effectiveness. This structure reflects the format of NHS Quality Accounts reporting and therefore provides a good structure for Trust-wide quality and safety reporting, which is reflected in parts in CSU governance reporting structures.
Quality Strategy

The 2013-18 Quality Strategy provides a strategic vision, core values and recovery as the underpinning care philosophy.

We discussed the Quality Strategy with different board and senior staff members including the board secretary and found general consensus around the need for further refresh and update. We also noted that Board Development Meeting notes show that Board members are aware of the need for further work on the Quality Strategy, confirming that this is a key area for review.

Suggestions for improvement

Some of our recommendations for an improved Quality Strategy are based on comparisons with other organisations’ quality strategies together with recommendations from national policy. They include:

- Reference to on-going work around the Francis Report recommendations.
- Ways in which the Trust is responding to Government’s response to the Francis Report ‘Hard Truths’ (2014).
- Ways in which the Trust is implementing the recommendations of the Berwick Report ‘A Commitment to Act’ (2013) which specifically provides guidance on developing the right culture for safety and quality improvement.
- Link with organisational values and NHS Constitution.
- Include risks and mitigations to delivery of the Strategy and how they will be monitored.
- Simplified board to ward quality reporting structure.

This refresh would aim to create a contemporary and proactive approach to quality which clearly demonstrates leadership and commitment from the board and senior managers for regular and transparent engagement with quality strategy, vision and direction. The ways in which the Trust plans to move to proactivity should be set out in the strategy with clear milestones to be reached which can be reviewed.

The revised strategy would demonstrate systematic approaches for engaging staff and other relevant stakeholders in its development and the development of appropriate indicators to monitor its success. It would be current, being based on local and national policy developments.

Implementation of the refreshed Quality Strategy would require a commitment from senior managers who are trained and capable to implement the strategy in complex and changing settings. This could be linked with existing leadership development programmes or practice accreditation schemes.

Our discussions with clinical managers identified an appetite for quality and quality improvement but some staff experienced confusion with the range of development initiatives in place. A refreshed Strategy would help demonstrate the relationship between various organisational strategies and initiatives and progress towards achieving key priorities.
It would also make clear how identified risks to quality would be managed through the refreshed Quality Strategy.

Creating the culture for quality improvement

On-going reference/benchmarking against the Francis and Berwick report recommendations would demonstrate positive and proactive action to further stimulate improvement. This requires:

- Demonstration of ways in which quality performance management will shift to quality improvement.
- Help staff understand their individual role in quality improvement.
- Challenge management to provide a culture for improvement.
- Move from a blame culture to a supportive risk taking culture.
- Challenge staff to commit to act and commit to improve.
- Giving staff permissions to make local improvements.
- Capacity and capability programme around quality improvement.
- Include statements about culture/ transparency/ openness / candour.
- Make visible corporate accountability & responsibility – who is responsible for what.
- Replicate key components of the corporate structure in CSU structures.
- Visual display of the Trust-wide quality reporting structure to show where each staff member fits within the ‘big quality picture’.
- Explain the executive & non-executive role in leading quality & safety.
- Ensure the strategy speaks to the full multidisciplinary team.
- Consistent visual display of the strategy against organisational values which can be replicated across units for ease of understanding and recall for staff.

Measuring improvement within the Quality Strategy

- Present a more quantifiable framework (for example success against the 7 step model could become more quantifiable).
- Demonstrate how quality reporting will flow from ‘ward to board’ with certain high level metrics becoming more granular at CSU and team level.
- Include some patient narrative to emphasise impact of quality on patient outcomes.
- Promote the use of visual quality boards in clinical areas to display quality, safety and improvement data and help staff see their local safety and quality ‘picture’.

Engagement in the big quality issues

- Display clearly how the overall strategy affects CSUs and local services.
- Encourage local scrutiny through peer review / quality collaboratives.
- Provide clear links between the Quality Strategy and the Quality Accounts.
- Improve visibility of Quality Accounts and in year progress reporting.
- Use improved trend information for local and corporate reporting.
- Staff recognition awards reflect the main quality priorities.

We believe that attention to the above will help to move from a quality performance and assurance position to one which embraces proactivity and quality improvement.
A driver diagram to show strategic approaches to quality improvement:

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<tr>
<th>Development of a proactive culture of quality improvement</th>
<th>Constancy of purpose</th>
<th>Quality Vision &amp; Strategy</th>
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<td>Set of methods &amp; tools</td>
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<td></td>
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<td>Position in Region &amp; UK</td>
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<td>Will &amp; energy for improvement</td>
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<td>Prioritising of ‘real’ problems</td>
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<td>Appreciation of each other’s work</td>
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<td>Space for learning &amp; reflection</td>
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<td>Research in QI</td>
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<td>Leadership for improvement</td>
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<td>Collaboration across units &amp; disciplines</td>
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<td>Exchange with peers in UK &amp; abroad</td>
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<td>Organising for improvement</td>
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<td>Attention to microsystems &amp; transitions</td>
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<td>Improvement capability</td>
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<td>Infrastructure for data</td>
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**Role of the Board in Implementing Strategy - Board Development**

We were interested to speak to the board chairman, directors and senior managers to ascertain feelings about board leadership, board relations and visibility of board members to frontline staff. We felt these were important factors to promote the leadership profile within the Trust and demonstrate a commitment towards quality and safety leadership.

We heard of strong support for the CEO from various board members and that staff appreciated his mental health professional background and experience. However the chairman reported recent instability and ‘churn’ within board membership which was affecting a consistent approach to leadership.

We reviewed the 2014 board development programme and notes of meetings which have taken place over the past year. The programme looks comprehensive, relevant and
responsive to emerging needs. We were not clear how the impact of the board development programme is being evaluated.

Review of a year of board development sessions show an active and diverse range of topics, with examples of the board meeting with patients to hear of their experiences directly (this included high secure services).

We heard that a board self-assessment exercise has been completed and the board development programme is responsive to those outcomes, however the planned 360 degree self-assessment for board members has not yet taken place due to changing board membership and the recent news that the chairman will be leaving.

Our discussions with the board members, chairman and non-executive directors indicated a healthy focus on assurance at board level but not much discussion around a proactive approach to quality improvement as a strategic aim.

Our review of governance internal audit reports showed an acceptable level of assurance across all areas reviewed suggesting that the climate is right for a planned and proactive shift towards quality improvement, as defined and explained in the 2013 Berwick report.

Discussions with the interim director of nursing, executive directors for clinical services and the corporate governance team revealed that there has been a lot of work completed to review and refresh the main corporate strategies however we observed that there was some disconnect between these activities.

One executive director described ‘initiative fatigue’ experienced both at executive level as well as in operational teams. This appears to be leading to lack of support between some executive directors and lack of ownership of strategic leadership and engagement across the breadth of initiatives being trialled. Specific examples were the Trust leadership programme and Trust talent management initiative which appeared to have varied support in strategic implementation, with the perception that they served certain clinical services and professions better than others.

The board development programme is designed to strengthen the executive team to work as a ‘unitary board’ with emphasis on improved ownership of Trust-wide strategic initiatives. The executive and non-executive members we spoke to felt positive about the intentions and the content of this programme and its potential to strengthen understanding and ownership of Trust-wide strategy.

During our meeting with the non-executive directors we agreed that it would be useful to consider scenario planning around unexpected serious incidents and how the whole board would work together to ensure an appropriate and proportionate response.

The non-executive directors expressed a desire to meet together outside of formal board meetings to get to know each other better and to understand what each member had to offer.

Positive findings

- Board and non-executive skills profile has been undertaken.
- Responsive and active board development programme.
- Board self-assessment exercise has been completed.
- Confidence that ‘we are on the journey to becoming a unitary board’.
- Interim executive and senior management posts are being filled with substantial posts.
- Clinical staff knew key members of the executive team and felt able to contact CEO through initiatives such as ‘Ask Steve’.
- Increasing visibility of the chief executive & executive team.

**The board member visiting programme**

We viewed the board member visiting programme (2014) and could see inclusion of a diverse range of services and that the focus in 2014-15 is to visit local services.

Conversations with executive and the non-executive directors identified the need for clarification around the purpose of the visits. They didn’t appear to be related to any specific strategy or initiative and we heard of varying levels of commitment and engagement. A refresh of the programme and its purpose is recommended with a clear link to a strategic aim and purposeful use of the information obtained during the visits. The non-executive directors also felt that sometimes the visits felt a little ‘too well choreographed’.

There was also a suggestion by the non-executive directors that the visits programme could include an overview of safety and quality data which would help them gauge a more informed picture of local safety and quality.

**Broadmoor**

We identified the need for higher profile and improved visibility of board members on the Broadmoor site, although we have subsequently heard of actions to remedy this.

Additionally we heard that the board visiting programme does not include Broadmoor due to the community services focus. We note that board development sessions have taken place at Broadmoor and would recommend that members use such visits to meet with staff and help staff understand the role of and interest of board members. We would suggest an overview of the full range of opportunities for executive and non-executive presence and active engagement with staff and service users at Broadmoor.

### 9.3 Recommendations

**Quality Strategy**

Trust Board to review the Quality Strategy.

Quality Strategy review should engage staff and stakeholders in the process and with setting key indicators.

Show how the Quality Strategy will move from a reactive to a proactive approach to quality and safety.

Quality goals should be specific, measurable & time bound (Monitor 2014).
Implementation of the refreshed Quality Strategy will require a commitment from senior managers who are trained and capable to implement the strategy in complex and changing settings.

Agree periodic review of achievement of the key strategic quality aims.

**Board Development Programme**
Continue work with non-executive directors to better understand their role.

Board development programme to focus on loyalty and commitment from all executive directors to support full range of strategic objectives across all services and professions to address perceived ‘disconnects’.

Consider ways in which to improve the profile of board members on the Broadmoor site.

Evaluate the impact of the board development programme.

Undertake the planned 360 degree board development exercise and link outcomes to strategic accountabilities.

The whole board to engage in serious incident scenario planning to consider how the board members would work together to ensure an appropriate and proportionate response.

**Board member visiting programme**
Review the board member visiting programme and its purpose and role in improving quality & safety (linked to strategic objectives).

Continue to raise the profile of the board during any visits to Broadmoor.

9.4  Board governance - Reporting Structures & Processes

**Well led questions**
Are there clear roles and accountabilities in relation to board quality governance?

**Introduction (context) what we would expect to find:**
We would expect to find a clear and well-functioning system of accountability as set out in ‘ensuring robust accountability’ (Hard Truths, 2014).

In April 2013, Monitor published a guide for Trust boards on how to ensure organisations are working effectively and asks the key question ‘How does a board know that it is working effectively to improve patient care?’

This was a key question that we used to focus our review of reporting structures and processes.

9.5  Findings, analysis and suggestions

**Governance structure**
A cohesive governance structure is vital to enabling robust and effective reporting lines from the operational level of the Trust at Clinical Service Unit (CSU) levels right through to the
Trust Board. Inclusive and accountable governance processes are required to achieve success in clinical outcomes leading to a higher quality of patient care.

An internal audit of governance was undertaken in August 2014 as part of the Trust’s approved internal audit periodic plan for 2014/15 which reported a judgement of ‘reasonable assurance’. This finding provided the background for our governance review as we were keen to use existing assurance to inform our review and avoid additional burden for staff.

Positive findings

- The Trust provides a diagram of its governance structure from CSU level to Trust board (Appendix to Quality Accounts 2014-15).
- Internal audit judgement of reasonable assurance for 2013-14.
- Work is on-going to implement a new governance structure which intends to remove over-reporting and duplication of reporting.
- This new governance system will be trialled in Broadmoor with the potential for planned Trust-wide roll-out.
- The development of the new governance structure is being led by a Clinical Director who has liaised with the corporate governance team and senior management team to achieve engagement.

Governance reporting at CSU level

Our discussions with staff informed us that existing governance reporting systems are cumbersome and that there is duplication. We found conflicting accounts around how well staff at various levels of the organisation understood the governance reporting system and this leads us to agree with the August 2014 internal audit recommendation:

‘The Trust should consider developing a solid, robust governance framework which can provide guidance to the entire organisation around what is expected of each of the Groups and Committees and how these link together. To assist with this, the Trust could review the functions of each of the groups at CSU level to ascertain whether or not some of these could be integrated together. This should help minimise the risk of information not flowing through the appropriate channels on a timely basis’.

Clinical staff we spoke to were not clear of the flow of governance (meetings at Broadmoor, Solaris which is a low secure ward and Jubilee ward in the Older People’s services). There was some confusion as to the terms of reference of CIG and TIRG meetings and what quality data and information should be covered in local team meetings. Staff also felt that there were many governance type meetings to attend, often resulting in repetition.

Ward based staff informed us of confusion arising from the ‘seeded out’ governance arrangements in terms of accountabilities and responsibilities for data collection, reporting and feedback to staff.

We were interested in the extent to which quality data was used in local team meetings and found some inclusion of patient experience and safety (SUI) information in team meetings but this varied considerably as to the nature and quality of data. Staff could not always tell us how they were learning across CSUs.
However, we did find evidence of cross departmental activity with regards to Serious Incident investigations and safeguarding investigations which provided opportunity to learn from other units and other CSUs. This and other opportunities to share across CSUs should be encouraged as staff told us that they valued this wider exposure.

Seeded out governance arrangements

We heard of the decision to ‘seed out’ governance across the CSUs with the intention of providing local governance support to clinical staff. Few people disagreed with the central principle of bringing governance closer to frontline staff, but we heard of tensions arising from this arrangement throughout our visit.

Historically the seeding out of governance involved:

- Transfer of some members of corporate governance staff to CSUs.
- CSU based governance leads working alongside clinical teams and providing direct governance support to clinical teams.
- Changed line management arrangements for the seeded out staff.

During our review it became clear that there are tensions between the seeded out staffing arrangements and the corporate governance functions. These include:

- Line management arrangements (governance seeded out staff being managed by operational management with competing priorities and perspectives).
- Seeded out staff being drawn into operational and clinical management functions.
- Different seeding out arrangements and responsibilities in different CSUs.
- Communication and decision making problems due to seeded out staff not attending corporate governance meetings.
- Authority problems with regards to requests for data collection across CSUs.
- Lack of understanding as to the responsibilities of the Clinical Directors who are accountable for governance in their respective service lines.
- Problems with data and information flowing across the organisation with a perceived ‘gap’ between corporate governance and governance within CSUs.
- Information sitting at CSU level and not being reported to board.
- Poorly defined structure for cross CSU sharing and learning.

We were particularly concerned to hear ‘we are not seeing trends over time as different CSUs report in different ways’.

We consider this to be a risk to the organisation and would recommend an entry on the Trust risk register regarding this disconnect along with work to clarify accountabilities and responsibilities.

We noted that the interim Director of Governance presented a paper to TMT in Autumn 2014 with recommendations as to how some of the seeded out arrangements might be reviewed and we recommend that work is seen as a priority for the Trust.
We assert that there is work to be done with regard to confidence building between operational and corporate governance functions and responsibilities, led by executive directors to ensure the effectiveness of the Trust’s governance systems.

**Proposals for a new Trust-wide governance structure**

The Clinical Director for Broadmoor has been leading on the development of a new and improved governance structure. It will be important to consult as widely as possible on this development to engage staff and to ensure that the new arrangements address some of the problems identified by internal audit as well as the findings of this report.

We would recommend the following before roll out of the new proposed governance structure across the whole Trust:

- Ensure that the internal audit findings are addressed.
- Undertake a thorough risk assessment.
- Consider measures that would indicate a successful change has been made.
- Test the new governance structure at Broadmoor as to its applicability and spread.
- Include ‘learning capture’ and use as an engagement and learning opportunity.
- Include more visual display to help staff understand the ‘ward to board’ system.
- Improve the way that quality and safety messages are filtered through to Trust frontline staff.

**Quality Accounts reporting**

We noted the quarter 2 Quality Accounts progress report that had been presented to SMT in November 2014. There are several quality, safety and effectiveness priorities that are not on target. To raise visibility of the Quality Account activities and reporting throughout the year we would suggest:

- A higher profile of Quality Account reporting at board meetings.
- Improvements to the Quality Account RAG rating system.
- Risks being raised where quality priorities are not being met (several targets had slipped since quarter 1).
- Improvements to delays in reporting.
- Higher profile of Quality Account priorities at CSU and team level.
- Clearer accountability for the tracking and reporting of the quality priorities.

**9.6 Recommendations**

**Governance structure**

*(Internal audit recommendation 2014)*

The Trust should consider developing a solid, robust governance framework which can provide guidance to the entire organisation around what is expected of each of the Groups and Committees and how these link together. To assist with this, the Trust could review the functions of each of the groups at CSU level to ascertain whether or not some of these could be integrated together. This should help minimise the risk of information not flowing through the appropriate channels on a timely basis.
We recommend further work to be done with regard to confidence building between operational and corporate governance functions and responsibilities, led by executive directors to ensure the effectiveness of the Trust’s governance systems.

We consider the existing seeded out arrangements to be a risk to the organisation and would recommend an entry on the Trust risk register.

Involve staff in developing any new governance framework (note Solaris ward comments: ‘a lot of remodelling and restructuring’ without staff involvement).

**Governance reporting at CSU level**

We did find evidence of cross departmental activity in Serious Incident investigations and Safeguarding investigations which provided opportunity to learn from other units and other CSUs. This and other opportunities to share across CSUs should be encouraged as staff valued this wider exposure.

**Seeded out governance arrangements**

A full review of the seeded out governance arrangements.

Ensure that data from all CSUs flows throughout the organisation in a standardised way that allows for seeing trends over time between and across the different CSUs.

New Trust-wide governance structure.

Test the new governance structure at Broadmoor as to its applicability and spread and use as an engagement and learning opportunity.

Ensure that centrally there is a view of low reporting services with regards to incident reporting, complaints reporting and safeguarding reporting and analysis of potential impact on other quality and safety data.

**Quality Accounts reporting**

To raise board level visibility of the Quality Account activity, progress and risks throughout the year alongside improved visibility of the Quality Accounts at clinical level.

**9.7 Measurement & Performance reporting**

**Well led questions**

Is appropriate information on organisational and operational performance being analysed and challenged?

Does the information the board receive support effective decision making?

Does the board use information to hold management to account?

**Introduction (context) what we would expect to find:**
This section of the report covers performance reporting, the ‘shift’ from quality performance monitoring to proactive quality improvement and appropriate data measurement and presentation for analysis and challenge throughout the organisation.

The Monitor well led framework states that ‘the board should use an integrated approach to performance reporting to ensure that the impact on all areas of the organisation is understood before decisions are made’.

We would expect a transparent integrated performance reporting system with high level board reporting backed up by a ‘pyramid’ of more granular reports scrutinised by sub committees, CSUs and individual services. We would expect consistent and current approaches to data measurement and presentation at all levels of reporting.

The effective collection and use of data needs to be dispersed throughout the organisation. The Berwick Report ‘A Commitment to Improve, A Commitment to Act’ (2013) suggests that all staff have a role to play and ‘the entire NHS should commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science and quality improvement methods’.

This requires strong strategic intent, good, reliable data collection systems and feedback of accurate and timely data to staff to enable them to improve services and make informed decisions as part of their ‘day job’. Berwick reports that ‘often when things go wrong, warning signs abound but these need to be sensitive to local practice and understood by well-informed staff’.

9.8 Findings, analysis and suggestions

Trust Board Integrated Performance Report

We reviewed the Trust Board Integrated Performance Reports for the past year:

Positive findings

- Performance against relevant national standards and regulatory requirements.
- Consistency of presentation.
- RAG rated system.
- Some trend analysis.
- Board hearing patient stories.

Things which could be improved

- Improved metrics covering safety, effectiveness and experience.
- Inclusion of Quality Accounts progress measures.
- Consideration of ‘always events’.
- Incident reporting to include measures of instances of harm.
- Move to improvement science approaches such as statistical process control charts to understand variation and trend analysis for improved decision making.
- Measurement of the impact of organisational strategy.
- More focus on service user/ patient experience.
- Proactive and action focused commentary.
• Selected ‘advance warning’ indicators.

We heard of improvements that had been made with regards to performance reporting from executives and other senior staff but we noted that staff still felt that the Integrated Performance report is too lengthy and constructed in a way that doesn’t lend itself to due analysis.

At our meeting with the non-executive directors we heard a request for less data and more information. The non-executive directors did not always feel that their requests for additional information were acted upon and felt that further attention could be paid to following up action lists and requests more closely.

There was a degree of consensus that fewer priorities would result in more concentrated in depth analysis and might help develop a sense of ‘early warning’ indicators.

We also heard suggestions as to how senior staff could make better use of existing data for intelligence for business development but that this would require improved measurement systems and improvements to current data collection and display. It was felt the consistent display of data and systematic collection and flow of data would be improved if the Integrated Performance Report became the responsibility of a single Director.

**Measurement - Quality & Safety Data at Board level**

We found potential for fragmentation of reporting due to different reporting systems and key priorities sitting unrelated in different strategy documents, being monitored by different groups. For example, it is unclear how the quality strategy priorities and the seven Quality Account priorities align. It appears that the Quality Account priorities are reviewed by 4 separate groups across the Trust. We feel that this fragmentation interferes with transparency and overall accountability for achieving the Trust’s key safety, effectiveness and experience priorities.

We noted that the key priorities for safety, experience and effectiveness do not get reported in the monthly Integrated Performance Report. In fact we found little account of any triangulation of patient experience data being presented at Trust board level.

Berwick (2013) recommends that ‘all leadership bodies of NHS-funded health care providers should define strategic aims in patient safety, and should regularly review data and actions on quality, patient safety and continual improvement at their Board or leadership meetings’. Patient experience is key to understanding safety and quality.

A mix of quantitative and qualitative data can be triangulated meaningfully. Patient stories are being heard by the board and this rich source of information could be further backed up with patient experience data and intelligence collected during the Board member Visiting programme to provide a fuller picture of patient experience. Patient experience monitoring seems to sit at the ward level with data obtained through the Meridian system. We did not see a Trust-wide analysis of Meridian experience data or progress with regards to the set questions that are routinely asked. We did hear difficulties with systematic use of Meridian and that the set questions did not suit all environments. For example asking the same questions weekly to long term service users was not felt to be appropriate by the staff we spoke to. This suggests more sophisticated and innovative ways of capturing true accounts of patient experience.
Data and Measurement

Certain principles are driving modern thoughts on data and measurement which include the shift towards uptake of improvement science methodology. This includes systematic approaches to data measurement and presentation which helps us to understand levels of variation in operating systems and ways in which to continually seek to make improvements, wherever we sit in the organisation.

A key principle is that healthcare organisations should shift away from their reliance on external agencies as the guarantors of safety and quality and move toward proactive self-assessment and accountability on their own part, driven by their own improvement plans.

Transparency is a key principle of improvement science, which should be complete, timely and unequivocal. As much non-personal data on quality and safety, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public. This calls for confidence in data collection systems and skills in data analysis such that confident accounts can be presented.

Measurement - Quality & Safety data at CSU & team level

Patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line (Berwick 2013).

Board level performance reporting should be replicated by a system where the CSUs and frontline teams (service line reporting) receive performance feedback in the form of clinical quality dashboards.

Organisations should routinely collect, analyse and respond to local measures that serve as potential early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics.

Early warning indicators

We asked executive board members and senior staff in the CSUs whether another ‘Savile like’ situation could arise. Whilst we were reassured that this could not happen again, staff were less sure of what the tell-tale signs might be that something is going wrong. Berwick promotes the formulation of early warning indicators, which when triangulated start to use data as intelligence. Much of this work is at an early stage nationally but attention to early indicators based on the Savile report and subsequent learning at WLMHT would be advised.

Heatmap development

The Director for Governance talked us through ‘the heatmap’ which is a recent development and presents triangulated data at ward level in an early attempt to identify ‘hot spots’. This is a proactive initiative which has potential to develop into an early warning system for the Trust.

We were unsure as to how this approach will be introduced Trust-wide and how clinical staff are inputting to its development. In fact one executive director was dismissive of its ability to work across all of the CSUs. We viewed the heatmap as an excellent early attempt to triangulate data and make informed decisions about the quality of a service. We would
recommend small scale testing of the heatmap prior to roll out across all services and that staff are invited to comment on what their critical indicators might be across the different services.

We would also advise that any review of the Quality Strategy incorporates new initiatives such as the heatmap so that its place in the overall strategy is clear.

**Incident Reporting**

Our brief review of incident reporting included review of the Trust Incident Review Group reports. These provide detailed monthly breakdown of the types and numbers of incidents at CSU and team level. There is extensive narrative on the types and frequency of incidents, but we felt that the reporting could be improved by more detailed trend analysis and a more proactive and accountable response as to the required actions to be taken. This would help with identifying what interventions have been successful and tracking actions following reporting.

The incidents are not routinely profiled by harm, potentially masking the amount of harm that patients and service users might be experiencing. For example the falls reporting does not indicate how many falls resulted in harm, which is a key piece of safety information. It also masks multiple harms that service users might experience. Triangulation of incidents with harm, risks and complaints might provide a more informative local picture of patient safety and experience.

**Positive findings**

We heard of attempts to improve consistency in the way that data is presented across the CSUs from the corporate governance team and a willingness to improve existing reports.

There is a current attempt to implement a Trust-wide single agenda for team meetings across all CSUs which is based on the CQC 5 components for safety and quality. This encourages scrutiny of local performance data and quality and safety data and is applauded along with any other methods to support frontline staff in using data to make local improvements and improve consistency of approach.

We also note that the proposed new governance system that is being trialled on the Broadmoor site incorporates elements of improvement science such as statistical process control methodology for interpretation of data.

**Quality Improvement**

Berwick (2013) states that collaborative learning through safety and quality improvement networks can be extremely effective and should be encouraged across the NHS. The best networks are those that are owned by their members, who determine priorities for their own learning.

We met with a clinical team on one of the wards in Broadmoor high secure services who had started work on the ‘Safewards’ improvement initiative. They were looking to work collaboratively and to share learning with other clinical areas. This local quality improvement interest was very encouraging and staff stated they would appreciate support and further education around quality improvement methodologies.
Our early discussions with outgoing Finance Director explored quality improvement strategic intentions and we heard of growing interest but no formal strategy. A group from the Trust had been to Unipart looking at Lean methodology for Clinical Director development, but this approach appears most suited to the forthcoming service transformation programme.

We spoke to the Senior Management team on the Broadmoor site who felt that quality improvement was difficult in high secure services due to few sites to benchmark against, this statement was disappointing in that locally driven quality improvement does not rely upon benchmarking, possibly indicating the need for quality improvement awareness training for senior managers.

We also met staff at Broadmoor and in low secure services who were actively participating in a Royal College of Psychiatry peer review initiative and this seemed an ideal opportunity for development of a quality improvement collaborative.

**Local visual display of quality & safety data**

A key feature of quality improvement is to openly display quality and improvement data. We did find quality boards in some of the ward areas we visited, however these are used in a limited at way present.

We heard of a 'lapse' in a falls reduction programme on Jubilee ward and feel this is an ideal area for a quality improvement programme which would require the introduction of a proactive falls management improvement programme and open display of data available for all to see progress made.

We saw some local use of patient experience data with display of appropriate responses on quality boards which showed interest and proactivity. However, we did not see any evidence of wider quality collaboratives designed to systematically share learning and spread learning or share improvements that had been made.

Although our contact with community services was limited, we did not find examples of quality improvement or visual display of quality data during our discussions with the community team.

**Reflections and Conclusion**

It is recognised that many health care organisations at present have very little capacity to analyse, monitor, or learn from safety and quality information. Berwick states that this gap is costly, and should be closed. If we are to understand variation in quality either at local team level or organisational level, there needs to be investment in systems, processes and capability building for staff. More sophisticated measurement and data collection can help indicate successful interventions as well as provide ‘early warning systems’ for when things start to go wrong.

**9.9 Recommendations**

**Integrated Performance Report**

The Board to consider a shorter Integrated Performance Report focused on fewer priorities.
The Integrated Performance Report to become the responsibility of a single Director to improve consistent display of data and systematic collection and flow of data.

Include key safety & quality priorities for safety, effectiveness and experience in monthly board performance reporting.

Consider how best to optimise triangulation of data at all levels of the organisation.

**Measurement & data at Board level**

Devise a quality improvement strategy which includes an education programme for quality and patient safety sciences to include new recruits, as well as being part of the lifelong education programme for all staff.

Expose all health care professionals, including managers and executives to improvement science method and adopt systematic approaches to quality improvement.

The Trust should invest in a quality improvement capacity & capability building programme to enable staff to contribute to improvement of the quality and safety of services to patients.

The new proposed governance system should support the move to improvement science and statistical process control methodology for interpretation of data.

**Measurement and data at CSU and team level**

Implementation of team/ service level quality/ clinical quality dashboard to assist clinical decision making.

Support staff to access team level data & quality reports from the Exchange system.

Much of this work is at early stage nationally but we would recommend attention to developing early warning indicators based on the Savile report and subsequent learning.

Test the roll out of the heatmap as to its suitability for all CSUs to encourage engagement.

Implement and audit the Trust-wide single agenda for team meetings that encourages scrutiny of local performance data and quality and safety data.

Address the on-going difficulties with the Meridian system to improve capture of patient experience and consider different questions for different CSUs.

Any data reporting developments will need to be structured in line with the new service line reporting system which will offer an opportunity for further team level breakdown quality & financial data and performance.

**9.10 Risk Management**

**Well led question:**

Is the board sufficiently aware of the potential risks to the quality, sustainability and delivery of current and future services?

**Introduction (context) what we would expect to find:**
The main risks associated with current & future services are identified, with no significant control issues. Risk areas are monitored and reported in the Integrated Performance Report.

Risk registers are dynamic with evidence of regular review and update.

There is an effective process in place to monitor, understand & address present & future quality risks.

9.11 Findings, analysis and suggestions

Risk Management

We found evidence that there is regular and active review of risks as Trust-wide risks (level 1) are reviewed at each board meeting and are presented in the Integrated Performance report with the date of review and changes to risk grading included. This leads to good tracking of changes to risks and effectiveness of mitigation. However it is not clear within this report how long the risk has been open, leaving little evidence of how dynamic the risk register is.

The internal audit governance report (Baker Tilley, 2014) did not raise any concerns or recommendations pertaining to the design of the Trust’s control framework. The report states that the Trust has a Board Assurance Framework (BAF) in place that links the overarching Trust strategic objectives with the risks of not meeting these objectives. Within the BAF, key controls are detailed to mitigate risks, in addition to controls, assurances on controls, gaps in control and action plans in place to mitigate the risks identified. Progress against identified risks is monitored by the Quality Assurance Committee and any new risks are also approved by this Committee before the Trust Board is provided with an update on progress and any new risks.

Risk management at CSU level

The Lessons Learnt internal audit report (2014) reported on lessons learnt from Serious Incidents. It reported on the need to evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied at CSU level.

From review of the local CSU risk register the report confirmed that it is adequately designed to include a detailed description of the risk, risk commission and impact/likelihood of the risk. All risks on the local risk register had been RAG rated.

During our visit, we identified some issues with ownership of local risks. This concurs with the internal audit report that found that in some cases the risk owner had rejected management of these risks, feeling they were not responsible for managing the particular area. The risk register does not demonstrate whether a risk owner has been replaced. Failure to replace a risk owner leads to the risks not being effectively monitored and managed, we agree with the report recommendation that local risk management systems need to be improved so that ‘all risks should be managed by an appropriate risk owner’.

We were interested in the extent to which risk related reporting lines are in place (Monitor well led framework 2014). Staff we spoke to in high secure and older people’s clinical areas were not aware of the Trust’s top risks. Staff in the low secure clinical setting were aware of them. Staff were more aware of their local risks but not entirely sure of progress with regards
to closing actions or wider dissemination of learning from risk management. Learning within CSUs was felt to occur as reported by staff but frontline staff were unsure as to the extent of learning across CSUs.

We noted that our discussions with staff focussed more on incident management than risk management. Interestingly, review of the local governance systems appear to concentrate more on incident management than risk management. The introduction of the new team level quality agenda for team meetings will help encourage a wider review of incidents, but we note that it needs to include risk management as a prompt to promote analysis of and learning from a mix of incident, patient safety and risk data at local level.

Risk management & corporate governance
The corporate governance team discussed some concerns regarding accountability for risk management at CSU level due to the ‘seeded out’ arrangements and felt it was timely to review these arrangements with the intention of improving transparency and accountability.

We heard some concerns from one governance team member that the Trust arrangements for managing risk effectively (i.e. ensuring the correct recording, reporting and monitoring of risks on the Trust risk register) may be inadequate due to resourcing issues.

We were informed that the CSUs each have a risk management resource for providing it with competent advice on compliance with the Trust Risk Management policy. However there is no similar resource for the corporate services, which includes the medical directorate, nursing & patient experience directorate and the capital, estates & facilities (CE&F) service. Therefore, the risk registers for these directorates appear to be ‘under-populated’ and may not capture adequately all the significant risks that exist across the Trust.

Historically, there was an audit and periodic review of the effectiveness of the Trust’s risk management arrangements however following the re-organisation of the governance team in July 2014 there is no longer sufficient resource to carry out these reviews. We would support the governance team in that audit of this nature needs to take place.

Cost Improvement Programme (CIP) and risk assessment
We discussed the Trust CIP and how senior management would know that quality and safety are not compromised as a result of driving efficiencies. We heard and saw evidence of a robust impact assessment framework; however we also heard concerns that staff were not completing the necessary documentation which left some concerns about assurance around impact of CIP efficiencies.

Claims
We were informed by the central governance team that ‘the arrangements for learning lessons from claims may be inadequate’ and that the content of Trust policies may not be kept current (and, therefore, the content may not reflect current or best practice).
Currently, for those policies which are not closely related to BAF risks (e.g. ‘Consent to Examination & Treatment’, ‘Copying Letters to Patients’, ‘Health Records’), there may be inadequate arrangements in place for auditing whether policy compliance monitoring is taking place as described in each policy (and reporting the audit findings to the Trust).

Learning Trust-wide lessons from health & safety reviews can be improved. We were informed that these arrangements should ensure the correct reporting and investigation of ‘health and safety’ incidents and learning lessons from those incident investigations.

Risks noted at Broadmoor

During our meetings with a range of staff members at Broadmoor which included nursing staff and support staff (including porters, maintenance staff and cleaning staff) we were told that they felt they faced extra risks due to recent difficulties in covering shifts and cancelled activities which resulted in patients’ boredom and inactivity. This was a recurring theme, which further surfaced in our discussions with trainees and patients. We noted that the executive director informs the Trust board of cancelled activities in each board report and that a system is in place where certain activities will not be cancelled. We also note improvements in recruitment on the Broadmoor site; however we suggest that some thought be given to ‘always events’ to help support staff and patients who feel risk is heightened by cancelled activity.

9.12 Recommendations

Enhance risk reporting to provide further evidence of how dynamic the risk register is by ensuring a risk profile that shows the length of time that risks have been open.

Risk management to be included in the board development programme.

Ensure effective reporting mechanisms for flow of risk information from board level to CSU level.

Review effectiveness of risk management within the ‘seeded out’ governance arrangements with the intention of clarifying roles and accountability.

Improve visibility of organisational and local risks to frontline staff.

Governance team review arrangements for audit of Trust-wide risk management processes to include policy review.

Executive directors develop ‘always events’ based on risks made to known to them by staff and patients when they feel risk is heightened due to gaps in therapeutic and clinical processes.

The introduction of the new team level quality agenda for team meetings needs to include risk management to promote analysis of and learning from a mix of safety and experience data.

The risk register does not demonstrate whether a risk owner has been replaced. Failure to replace a risk owner leads to the risks not being effectively monitored and managed, we agree with the internal audit report recommendation that this needs to be rectified.
All SUI actions that are not implemented must be recorded onto the risk Register. Local audit should confirm this is happening.

Review the quality impact assessments to ensure that staff are completing the necessary documentation regarding the impact of CIP efficiencies.
10. **SECTION 3 – SAFEGUARDING**

Section 3 covers the following Savile Report recommendations:

**Recommendation 4**

Procedures to safeguard vulnerable patients were poorly developed and potentially ineffective during Savile’s active involvement at Broadmoor, including the reporting and proper investigation of complaints. We believe that safeguarding has been greatly improved and that procedures are appropriate and effective, but we recommend that the way theory is put into practice should be reviewed regularly. We also recommend that the arrangement that separates local authority responsibility for safeguarding from the provision of social workers should be reviewed within the next year, and that a risk assessment and appraisal of alternative options should be carried out.

**Terms of Reference**

To undertake a review of Trust-wide safeguarding arrangements for both children and adults at risk, including a review of current assurance processes regarding the effectiveness of such arrangements.

This section includes:

**Safeguarding (working with stakeholders)**

- Safeguarding concerns
- Positive developments
- Grabpacks
- Boundary violations

**Complaints**

- Internal audit report (October 2013)
- Positive
- Improving time frame for closing complaints
10.1 Safeguarding (working with stakeholders)

Introduction

We met with the Director responsible for safeguarding and local authority leads and social work managers at Broadmoor Hospital and spoke over the telephone with external safeguarding leads. The leads advised us that they found the Trust to be “open with reporting no real concerns”. They are invited to safeguarding meetings and are building good relationships with the Consultant responsible for safeguarding.

There are good relationships with the partnership board. We also spoke with the Social Work Team Manager for the West London Forensic Services.

Broadmoor hospital is accountable to Bracknell Forest Safeguarding Adults Partnership Board. Both the Bracknell Forest Safeguarding Adults Team and the CQC are invited to strategy meetings and the hospital’s safeguarding adults panel to ensure transparency and external scrutiny when required.

The system of safeguarding children is well established. We heard of very thorough arrangements for safeguarding children during visits both at Broadmoor and in low secure services.

Those who have oversight for safeguarding reassured us, that whilst Broadmoor is still a somewhat ‘closed’ environment, the culture is changing. The Service Director was praised for her leadership and efforts in driving the change. We also heard that the past practice of employing several members from the same family was greatly diminished.

We sought the advice of an independent expert in safeguarding, a former Director of Social Services, who positively acknowledged the frameworks and partnerships in place. He advised that some of the processes were more thorough and comprehensive than in other areas he had reviewed.

Recommendation 4 of the Savile investigation required “that the arrangements that separates local authority responsibility for safeguarding from the provision of social workers should be reviewed within the next year, and that a risk assessment and appraisal of alternative options should be carried out”.

We are aware that a risk assessment undertaken by Daniel Anderson, Safeguarding Adult Lead, Broadmoor Hospital and Alex Bayliss, Head of Safeguarding, Adults, Bracknell Forest, has been completed. This is awaiting approval from the Director of safeguarding WLMHT, the Executive Director for High Secure Services and the Directors of Adult Services, Ealing Council and Bracknell Forest Council.

We have had sight of the report and noted the comprehensive nature of the document and thorough approach adopted. We believe that risk assessment is of a high standard and the conclusions reached are satisfactory.

We are also aware and assured that with the advent of the Care Act 2014, from April 2015, the local authority will have the legal powers to direct how services within their catchment areas undertake safeguarding duties.
10.2 Findings, analysis and suggestions

We are generally satisfied with the range of initiatives and processes in place and we were impressed with the knowledge, effort and conviction of those charged with implementation of and monitoring of the safeguarding policy.

Staff assured us that the culture is definitely changing with evidence of senior managers taking training seriously and of staff reporting on colleagues where they had concerns. We were informed that the last occasion that this occurred it went to a full disciplinary hearing with the reporting staff member being comprehensively supported.

We ascertained that the most common types of incidents occurring are:

- Patient to patient
- Monetary abuses

We noted a recent initiative to report to the adult safeguarding meetings all safeguarding referrals across all services. This facilitates oversight so as to identify low reporting services. This is in its early stages and needs further development but is a very good attempt at ensuring consistent and thorough safeguarding practice.

Safeguarding concerns

We noted a small number of concerns and areas for further development:

A ward we visited had not made a referral for over four years. The explanations given included, ‘not having any safeguarding issues of concern’ and ‘any problems are dealt with by the clinical team’. On further exploration it appeared that the threshold for external referral was very high with the team feeling they were expected to contain most if not all issues in this regard.

Positive developments

We noted a significant number of positive initiatives and developments including:

- Safeguarding level 1 training reported as much improved on Broadmoor site – a three hour generic programme safeguarding and refresher programmes available.
- Training figures have incrementally improved.
- A good number of leads are in place.
- Clinical governance meetings are now more frequent. There are two monthly incident review meetings. Also monthly meetings on safety and safeguarding.
- Discussions between Trust, Local Authority and CCG at the Local Authority Safeguarding Board about shared training.
- The Trust is in the process of finalising the job descriptions for the new posts of the named professional (adults) and a safeguarding adult trainer lead professional.
- Grab packs with relevant information are available in all wards at Broadmoor with threshold definitions included in the pack and emphasised in the training programme.
- In the West London Services flow charts and an aide memoire are available.
Currently, working up scenarios for training re what triggers a safeguarding referral, for example, an intended v non-intentional assault.

To prevent wards which do not report, a social worker at Broadmoor attends ward meetings and most meetings elsewhere.

We were told that audits take place against the safeguarding policy on a half yearly basis and an annual report is prepared for the Bracknell Forest Safeguarding Adult Partnership Board. Also a report is prepared for the Safeguarding Children Board. The report includes identification of trends.

There is an annual funded safeguarding conference.

A new reporting system will detect any ward or CMHT not making referrals over a defined period.

Engagement with other two high secure hospitals on safeguarding issues, including joint meetings with heads of social work, usually occurs at quarterly intervals.

The medium secure social work manager also has national quarterly meetings and safeguarding is a regular agenda item.

There are laminated posters displayed on ward walls at Broadmoor.

The development of safer recruitment principles for volunteers.

There are no volunteers at present in the West London services, but the same policy of vetting is applied to volunteers in community services.

On the West London site links have been made with the Council to enable Trust staff to engage in more specialist training; for example alerters and investigators. Further bespoke training has been commissioned.

Other concerns include:

- We considered there was a gap amongst some staff in understanding contemporary awareness and requirements.
- Some concerns were described in respect of staff not recognising and reporting safeguarding concerns, but we were told that this is improving.
- It was suggested to us that it would be helpful if medical staff became more aware of and involved in safeguarding activity.
- It appears that further work is required in Hounslow to ensure consistent application of safeguarding principles.
- There are some anxieties about safeguarding roles when service line reporting is introduced.

**Grabpacks**

We noted the exemplary initiative regarding safeguarding adults ‘grabpacks’ at Broadmoor. However on closer inspection we noted that a paragraph in the introduction to the pack explains that the definition for a safeguarding referral is set at a high threshold. It further explains that referrals are only to be made when there are significant concerns around risk and exploitation that cannot be dealt with by way of already established systems.

We were concerned that this definition is different to other services and the inconsistency could lead to uncertainty amongst staff who may work across or move services. We also consider that the same safeguarding standard should equally apply to high secure patients. When we discussed the concerns with the social work manager he explained that the
different threshold was to prevent being overwhelmed with inappropriate referrals which may consume a disproportionate amount of time in investigations.

In response to our concerns, the social work manager offered to review the threshold and invite discussion at a future local safeguarding meeting and to raise the issue with the next meeting of the high secure safeguarding managers.

We were told by the safeguarding team that to promote greater awareness and understanding, a reflective practice and supervision approach similar to what is available for social workers is to be introduced.

We consider that significant progress has been achieved in developing the safeguarding systems and processes. We believe that the board can be assured that effective partnerships, leadership and structures are now established.

**Boundary violations**

The numbers of boundary violations (inappropriate relationships between patients, or patients and staff) have improved and at the time of the review the HR Director was not aware of any problems. We were told that training is in place and that staff are much more aware of detecting and managing boundary issues.

We were interested to review any disciplinary investigations around boundary violations. We were provided with summaries of reported incidents for the last year and we were assured that they had been dealt with appropriately. One of these cases had resulted in dismissal.

This low number appears to be encouraging but we advise that all efforts are required to be alert to inappropriate behaviours and that staff are encouraged to report their concerns.

**10.3 Recommendations**

We would recommend:

- A review of ward specific safeguarding referrals reported on a monthly basis as well as at CSU level.
- High secure services to review thresholds set out in the grabpacks.
- High secure commissioners to attend more safeguarding strategy meetings.
- Reflective practice and clinical supervision, along the lines of the social work model to feature safeguarding and to be linked to the rollout of the nursing strategy.
- Undertake a review of incident reporting over time to see which wards are reporting via the incident reporting system and not reporting through the safeguarding route.
- That the findings of the 2014 safeguarding risk assessment review of Ealing Local Authority and Bracknell Forest social work arrangements be implemented.

**10.4 Complaints**

**Internal audit report (October 2013)**

Overall decision - Taking account of the issues identified, whilst the Board can take some assurance that the controls upon which the organisation relies to manage this risk are
suitably designed, consistently applied and effective, action needs to be taken to ensure this risk is managed.

**Positive**

The High Secure Service is a high reporter of complaints.

The complaints lead within the central governance team compiles an annual and quarterly 'Learning from Experience' report. This report provides a very detailed analysis of the complaints relevant to the period of reporting. The report illustrates trends in complaints and by themes which allows the Trust to identify the common issues arising in order to eliminate them. The report also analyses the Trust-wide distribution of complaints and details how effective their complaints handling processes are, broken down to each Clinical Support Unit.

By including a number of performance measures, it also ensures that all Clinical Support Units are complying with the Trust policy and ensuring complaints are handled in a timely manner.

**Improving timeframe for closing complaints**

This allows the Trust to analyse how effective its complaints management is as a whole and also into specific clinical support units.

The Exchange system allows all documentation to be maintained electronically, moving the Trust's complaints management to an almost paperless system.

### 10.5 Recommendations

That the Trust carries out a RCA (root cause analysis) for high risk complaints investigations (internal audit report finding 2014).

We found that the Trust’s Local Services CSU currently does not compile any reports directly from the Exchange system with regard to recommendations. There is a risk that although recommendations are escalated up to the central complaints team, locally, recommendations are not followed up adequately and some recommendations may remain unimplemented (internal audit finding, 2014).

There appeared to be a large number of complaints that were not upheld. We recommend a review of a sample of these complaints to test consistency of decision making.
11. OVERALL CONCLUSIONS AND RECOMMENDATIONS

Our role has been to objectively examine and ‘stock take’ progress in implementing the recommendations from the Savile Investigation and comment on current initiatives, ask what could be done differently to strengthen work underway and point to areas of concern for change and further improvement.

The conclusions and recommendations have been guided by the Terms of Reference.

We have fed back to senior management at regular intervals and taken their advice on the scope throughout the review - iterative and dynamic.

Whilst there have been limitations to our scope, time available and the sheer size and extent of the widespread locations of the Trust preventing visits to all services or meeting as many stakeholders as we would have wished, we believe that our review has been sufficiently comprehensive to have a thorough understanding.

From our extensive range of reading, attendance at meetings at interviews with a range of significant people, we hope that the Trust Board and staff and service users find our analysis of the report cogent and credible.

Whilst our primary focus is on assessing the implementation of the Savile recommendations and identifying any gaps or concerns, it is also important to be balanced and highlight the strengths of other services, of which there are many, so that they could be built on. We have sought to bring some fresh thinking, different perspectives and ideas, as well as addressing the key issues to aid the further development of the Trust’s strategies and goals.

We are aware of change and improvements occurring during the period of the review.

We also commend the investment and the necessary emphasis given to the development of leadership. It is critical that leaders are equipped to deliver what it is expected of them. However, we have proposed that the range of initiatives be evaluated and that the opportunity and selection for accessing leadership initiatives is reviewed. We also suggest that the core content of programmes are revisited and benchmarked against the fundamental patient safety principles and practice priorities described in the Berwick Report.

We have consistently heard of positive developments from a substantial number of sources, including service users, independent advocates and trainees.

This was affirmed by our own observations from visits to the services that the ethos, values and culture has significantly changed and improved.

We can confidently assert that service users are now much more central to planning and decision making and are treated with respect and their voices are heard and valued. We were particularly impressed with the patient’s forum at Broadmoor.

The Trust Board will specifically need to continue to regularly review their information requirements and control mechanisms in order that they understand the main drivers and impediments of a positive culture and ensure that safeguarding is constantly on their radar. They should continue to review their sources and systems of information in respect of
concerns and complaints and be satisfied that the policies are being adhered to and concerns dealt with appropriately.

This responsibility will be enhanced by Trust Board members increasing their visibility within services.

A further challenge is to achieve a consistency of approach to quality and service improvement. Attention will need to be given to a consistent set of measures applicable across the Trust, but also specific to each specialist service and be accessible to all stakeholders.

We are assured that the Trust Board and senior management and most clinical leaders have a good awareness of the main issues of concern.

We consider they understand the challenge of constant learning and continuous service improvement and that they are bringing a sense of optimism, ambition, imagination and commitment to progress and the necessary vigour in taking the service forward.
11.1 Overview of Recommendations

SECTION 1 - CULTURE

8.4 Recommendations - Capability & Culture – Transparency, Quality & Safety Focus

Culture

Sustained and constructive efforts to counter negative thinking and behaviours are required to prevent those who are disenchanted from undermining others.

That the senior management team continue to monitor cancelled patient activity and the effect on staff and patient morale.

Ensure that appropriate plans are in place to provide ample cover during known holiday periods such as August.

We suggest that the outcome of the March benchmarking exercise with the other high secure hospitals review should be considered not only by the Senior Management Team, but by the Trust board to confirm that the positive changes have been appropriate and have been sustained.

Leadership

We recommend that the Trust evaluates the current range of leadership initiatives and then develops a plan with reference to the Berwick leadership behaviours, to bring greater cohesion and focus to preparing/equipping managers and clinical leaders to fulfil their leadership responsibilities.

We recommend that the management proposed 360 degree exercise is implemented so as not to lose momentum within the leadership plans.

The senior management team should address the issues raised by the consultant medical group who appeared somewhat demoralised and gave the clear impression that they felt unappreciated and peripheral to the many management initiatives.

There should be personalised development strategies to help staff acquire the necessary understanding of the full extent of their roles, so that they can identify with and be committed to the Trust’s vision and objectives and be accountable.

Staff engagement

We would recommend that initiatives inviting direct communications with the chief executive and directors be replicated at senior management level.

8.7 Recommendations - Capability & Culture - Learning & Development

Creating a culture for learning

We would recommend that staff are encouraged to network, conference and publish as we have seen some excellent initiatives during our visits. We heard of healthy and well established relationships with local universities which we suggest could develop further into research and writing partnerships.
We encourage managers and staff to move from ‘the middle ground’ and aspire to be the best.

**Clinical supervision**

Clinical supervision is personalised to meet the different individual needs of staff who have different levels of skills and experience and monitored during managerial supervision.

Consider ways in which bank (and where appropriate) agency staff might benefit from clinical supervision or reflective practice opportunities.

The Trust should actively display the standards for clinical supervision and monitor the uptake across different services.

We strongly support efforts within the Nursing Strategy to strengthen clinical supervision and urge that time and resources for supervision are available.

**Blame culture & escalating concerns**

Consider wider measures alongside the national staff survey findings to constantly ‘temperature check’ staff confidence with raising concerns.

**Evidence of a Learning Organisation**

To evaluate the impact of training programmes on subsequent service provision.

We urge consideration be given to ways in which the positive practice ideas might be implemented.

We heard from governance staff that incident reporting ‘stays at CSU level and the optimising of learning and wider sharing of lessons learnt is not always followed through’. We recommend these concerns are addressed.

We urge that managers be encouraged and given the opportunity to actively participate in incident reviews to share knowledge across CSUs and the wider Trust.
SECTION 2 – REVIEW OF GOVERNANCE

9.3 Recommendations - Strategy & Planning

Quality Strategy

Trust Board to review the Quality Strategy.

Quality Strategy review should engage staff and stakeholders in the process and with setting key indicators.

Show how the Quality Strategy will move from a reactive to a proactive approach to quality and safety.

Quality goals should be specific, measurable & time bound (Monitor 2014).

Implementation of the refreshed Quality Strategy will require a commitment from senior managers who are trained and capable to implement the strategy in complex and changing settings.

Agree periodic review of achievement of the key strategic quality aims.

Board Development Programme

Continue work with non-executive directors to better understand their role.

Board development programme to focus on loyalty and commitment from all executive directors to support full range of strategic objectives across all services and professions to address perceived ‘disconnects’.

Consider ways in which to improve the profile of board members on the Broadmoor site.

Evaluate the impact of the board development programme.

Undertake the planned 360 degree board development exercise and link outcomes to strategic accountabilities.

The whole board to engage in serious incident scenario planning to consider how the board members would work together to ensure an appropriate and proportionate response.

Board member visiting programme

Review the Board Member Visiting programme and its purpose and role in improving quality & safety (linked to strategic objectives).

Include visits to Broadmoor in the programme.

9.6 Recommendations - Board Governance – structures and processes

Governance structure

(Internal audit recommendation 2014)

The Trust should consider developing a solid, robust governance framework which can provide guidance to the entire organisation around what is expected of each of the Groups and Committees and how these link together. To assist with this, the Trust could review the functions of each of the groups at CSU level to ascertain whether or not some of these could
be integrated together. This should help minimise the risk of information not flowing through the appropriate channels on a timely basis.

We recommend further work to be done with regard to confidence building between operational and corporate governance functions and responsibilities, led by executive directors to ensure the effectiveness of the Trust’s governance systems.

We consider the existing seeded out arrangements to be a risk to the organisation and would recommend an entry on the Trust risk register.

Involve staff in developing any new governance framework (note Solaris ward comments: ‘a lot of remodelling and restructuring’ without staff involvement).

**Governance reporting at CSU level**

We did find evidence of cross departmental activity in Serious Incident investigations and Safeguarding investigations which provided opportunity to learn from other units and other CSUs. This and other opportunities to share across CSUs should be encouraged as staff valued this wider exposure.

**Seeded out governance arrangements**

A full review of the seeded out governance arrangements.

Ensure that data from all CSUs flows throughout the organisation in a standardised way that allows for seeing trends over time between and across the different CSUs.

**New Trust-wide governance structure**

Test the new governance structure at Broadmoor as to its applicability and spread and use as an engagement and learning opportunity.

Ensure that centrally there is a view of low reporting services with regards to incident reporting, complaints reporting and safeguarding reporting and analysis of potential impact on other quality and safety data.

**Quality Accounts reporting**

To raise board level visibility of the Quality Account activity, progress and risks throughout the year alongside improved visibility of the Quality Accounts at clinical level.

**9.9 Recommendations - Measurement & Performance reporting**

**Integrated Performance Report**

The Board to consider a shorter Integrated Performance Report focused on fewer priorities.

The Integrated Performance Report to become the responsibility of a single Director to improve consistent display of data and systematic collection and flow of data.

Include key safety & quality priorities for safety, effectiveness and experience in monthly board performance reporting.
Consider how best to optimise triangulation of data at all levels of the organisation.

**Measurement & data at Board level**

Devise a quality improvement strategy which includes an education programme for quality and patient safety sciences to include new recruits, as well as being part of the lifelong education programme for all staff.

Expose all health care professionals, including managers and executives to improvement science method and adopt systematic approaches to quality improvement.

The Trust should invest in a quality improvement capacity & capability building programme to enable staff to contribute to improvement of the quality and safety of services to patients.

The new proposed governance system should support the move to improvement science and statistical process control methodology for interpretation of data.

**Measurement and data at CSU and team level**

Implementation of team/ service level quality/ clinical quality dashboard to assist clinical decision making.

Support staff to access team level data & quality reports from the Exchange system.

Much of this work is at early stage nationally but we would recommend attention to developing early warning indicators based on the Savile report and subsequent learning.

Test the roll out of the heatmap as to its suitability for all CSUs to encourage engagement.

Implement and audit the Trust-wide single agenda for team meetings that encourages scrutiny of local performance data and quality and safety data.

Address the on-going difficulties with the Meridian system to improve capture of patient experience and consider different questions for different CSUs.

Any data reporting developments will need to be structured in line with the new service line reporting system which will offer an opportunity for further team level breakdown quality & financial data and performance.

**9.12 Recommendations - Risk Management**

Enhance risk reporting to provide further evidence of how dynamic the risk register is by ensuring a risk profile that shows the length of time that risks have been open.

Risk management to be included in the board development programme.

Ensure effective reporting mechanisms for flow of risk information from board level to CSU level.

Review effectiveness of risk management within the ‘seeded out’ governance arrangements with the intention of clarifying roles and accountability.

Improve visibility of organisational and local risks to frontline staff.
Governance team review arrangements for audit of Trust-wide risk management processes to include policy review.

Executive directors develop ‘always events’ based on risks made to known to them by staff and patients when they feel risk is heightened due to gaps in therapeutic and clinical processes.

The introduction of the new team level quality agenda for team meetings needs to include risk management to promote analysis of and learning from a mix of safety and experience data.

The risk register does not demonstrate whether a risk owner has been replaced. Failure to replace a risk owner leads to the risks not being effectively monitored and managed, we agree with the internal audit report recommendation that this needs to be rectified.

All SUI actions that are not implemented must be recorded onto the risk Register. Local audit should confirm this is happening.

Review the quality impact assessments to ensure that staff are completing the necessary documentation regarding the impact of CIP efficiencies.
SECTION 3 - SAFEGUARDING

10.3 Recommendations - Safeguarding (working with stakeholders)

We would recommend:

- A review of ward specific safeguarding referrals reported on a monthly basis as well as at CSU level.
- High secure services to review thresholds set out in the grabpacks.
- High secure commissioners to attend more safeguarding strategy meetings.
- Reflective practice and clinical supervision, along the lines of the social work model to feature safeguarding and to be linked to the rollout of the nursing strategy.
- Undertake a review of incident reporting over time to see which wards are reporting via the incident reporting system and not reporting through the safeguarding route.

That the findings of the 2014 safeguarding risk assessment review of Ealing Local Authority and Bracknell Forest social work arrangements be implemented.

10.5 Recommendations - Complaints

That the Trust carries out a RCA (root cause analysis) for high risk complaints investigations (internal audit report finding 2014).

We found that the Trust’s Local Services CSU currently does not compile any reports directly from the Exchange system with regard to recommendations. There is a risk that although recommendations are escalated up to the central complaints team, locally, recommendations are not followed up adequately and some recommendations may remain unimplemented (internal audit finding, 2014).

There appeared to be a large number of complaints that were not upheld. We recommend a review of a sample of these complaints to test consistency of decision making.
12. APPENDICES

12.1 Appendix 1

Suggested organisational culture goals to aim for:

- Focussed and holistic care based on values which promote dignity, respect, compassion, a sense of purpose and meaningful connectedness, responsiveness and hope.
- Patient safety and quality of service to be central.
- Effective engagement of all staff.
- To have clear and open communication.
- To provide effective training, support and supervision for staff to prevent and manage patient incidents.
- To encourage and support clinicians in front line services and to create a culture and environment that motivates and inspires them to make services as good a quality and as safe as possible.
- To have more recognition, reward and improved compliment systems.
- To develop further, a more open and learning organisational culture including, a willingness to accept challenge and be responsive to change.
- Respecting and valuing the contribution of colleagues at all levels.
- To create an environment which promotes transparency and encourages staff to feel safe, report patient safety concerns and incidents, and when things go wrong say sorry, be honest and provide an explanation why and describe learning and action to be taken to prevent it reoccurring.
- A commitment to safe staffing levels.
- Publicise support available for staff involved in or affected by patient incidents.
- The Trust Board to receive timely reporting of incidents and have systems for learning, tracking and review.
- To be recognised as a valued local employer.
- To have a higher staff retention rate and recruitment of the highest calibre of staff.
- Be recognised nationally as an innovative health care delivery organisation.
- To have further nationally recognised clinical practitioners.
12.2 Appendix 2

Implications of a Negative Culture

It is likely to result in:

- Poor team or individual self-reflection and a lack of insight.
- Entrenched resistance to embracing positive change.
- Insular and isolated.
- Stuck in custom, tradition and practice.
- Lack of new ideas or approaches.
- Defensive, mistrusting.
- Tribalism between professionals and teams.
- Teams being territorial.
- Power struggles and conflicts.
- Cliques.
- Staff being disempowered, not able to speak up or out.
- Staff ‘happy to get by’, adopting the easiest approach.
- Indecision and uncertainty.

Features of a Positive Culture

A positive culture would more likely produce:

- Positive attitudes and behaviours.
- Quality focus, patient and carer/family member centred.
- Learning and reflective on performance.
- Nurturing and supportive.
- Leaders’ style is open, honest, sincere and capable of being humble.
- Enabling and empowering.
- Staff able to speak up and raise concerns.
- Dynamic, encouraging and inspiring leaders.
- Recognition of and cultivation of talents and strengths.
- Visionary, progressive and aspiring.
- Climate of effective team working and team development.
- Motivative commitment and passion.
- Innovative, creative and staff enjoying a measure of autonomy.
- Co-operative and willingness to engage with others and avoid conflict.
- Solution focussed.
- Respectful of the views and principles of others.
- Leaders having confidence in their staff and staff being confident in their managers and leaders.
12.3 Appendix 3

Organisational values, effectiveness, staff engagement and effective communications

- The process of engagement needs to be part of a corporate strategy and business plan.
- Important to get the message out, “Please report concerns, even if uncertain, or not in full possession of all of the facts.
- Invite comments on how to more effectively connect with the executive team.
- Have a heightened focus on complaints, staff surveys and exit interviews and seek to triangulate information and themes and give a comprehensive and complete picture of what precisely is causing concerns to staff, or wider patterns/themes which require investigation.
- Seek to rebalance power and autonomy by giving staff freedom, space and time to test out and make small improvements in their own area.
- Consider alternative methods of having a dialogue with staff and asking employees in ‘one to ones’ or in focus groups, important questions such as “What is going well in the organisation” or “What gets in the way” or “What makes a difference”?
- Aspire to a “culture with excellence at every encounter”, which values staff skills, ideas and embeds listening and openness and gives feedback.
- Senior managers/leaders to follow Chief Executive’s example by holding regular listening events, which are perceived as credible and meaningful by staff.
- Evaluate the present system of executive and non-executive walk arounds and visits to clinical areas; seek the views of staff on how they may be improved.
- Consider how information and key findings could be fed back to the clinical team and internal quality meetings and safety groups and published monthly as part of board papers.
- Individual services/directorates to be encouraged and supported in organising listening to and acting on staff suggestions and comments and give feedback on positive changes that have happened, in terms of, “You said, we did”. Also, to give explanations as to why not being taken forward.
- Run ‘road shows’ around the organisation with regular newsletter on quality and new developments internally and from other services.
- Consider a website and other social media opportunities, videos and graphics including library of useful information and documents and sources of advice and how to get involved. Ask how can we make them more colourful, attractive?
- Explore with staff how to make the working environment more pleasurable and fun to work in and an organisation to work for.
- To have appropriate devolving duties to maximise clinical expertise, skills and give sustained emphasis to the development of skills to aid career development. Staff to feel valued and prepared for succession planning and recognition of and visible career progression pathway.
- Increased support for staff health and wellbeing and workplace values to improve their workplace experience, which enables them to develop their role with care, compassion and commitment.
12.4 Appendix 4

Positive practice – care and treatment and safety

- The quality improvement journey requires patient safety to be central.
- To review and refresh professional nursing and HCP and medical forums to drive plans for evidence based and personal care and treatment.
- To review and ensure people with lived experience are included in service development, delivery and review.
- Review engagement with service users and family member arrangements to improve patient experience, purposeful and timely feedback and reporting to Board and quality groups to enhance services.
- Consider promoting patient and staff safety and specific quality campaigns to raise awareness and improve practice. Build on Safer Wards initiative.
- Agree commitments towards the delivery of high quality and safe care, for example, a 20% reduction in the most serious incidents.
- To review engagement in national programmes and benchmarking and improved implementation of NICE guidelines and based evidence based.
- Develop safe staffing levels as measured by the National Quality Board.
- Personal responsibility and accountability for the delivery of the highest standard of patient care to be adopted, promoted and improvements developed.
- Ensure staff have access to national leadership development programmes.
- Ensure all clinical staff to have clear and transparent quality and safe care expectations and goals.
- Explore innovative technology to help develop self-care and management toolkits.
- Explore new and refresh existing partnership with other clinical and professional agencies, including those in the Third Sector.
- Work with neighbourhoods to effectively identify support community needs and build on assets.
- Further develop carer and family support and involvement and build on Triangle of Care initiatives.
- Review policies and training practice to support positive risk taking.
- Explore how both service users and staff can be helped to develop resilience.
- Ensure there are effective health education resources are available.
- Encourage the workforce to become Advocates for whole person care.
- Simplify access to research and innovation opportunities.
- Introduce a ‘new ideas and innovation’ forum.
- Increase in research studies aligned to support improvements in clinical service.
### 12.5 Appendix 5

**Characteristics of a learning organisation:**

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<thead>
<tr>
<th>Characteristics</th>
<th>Description</th>
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<tr>
<td>The sharing of information within the organisation by creating a boundary-less environment.</td>
<td>A strong sense of teamwork to facilitate collaboration.</td>
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<td>Empowered teams and staff with little need for direction or control by managers.</td>
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<td>Managers and clinical leaders functioning as facilitators, support and advocates of teams.</td>
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<td></td>
<td>Leaders facilitating the formation of a clear vision for the organisation's future.</td>
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<td></td>
<td>An open culture of trust, with staff able to communicate, experiment and learn without fear of criticism or punishment.</td>
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<td></td>
<td>A strong sense of community and caring in the organisation.</td>
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<td></td>
<td>The structure and processes of the organisation, helps not hinder the staff in carrying out the organisation's functions.</td>
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