NHS
Bridgewater
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NHS Foundation Trust

Creating Safer Organisations

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Winterbourne View care home staff jailed for abusing residents

Six staff are jailed and five given suspended sentences after abuse of disabled patients was secretly filmed by reporter

Winterbourne View private hospital in Hambrook, south Gloucestershire. Photograph: Tim reland/PA

REVIEWS AND REPORTS

Fresh probe into safety failings at Liverpool community trust

06 JUNE, 2019 | BY GEMMA MITCHELL

A new independent inquiry has begun into up to 17,000 cases of historic patient safety failures at the former Liverpool Community Health NHS Trust.

Scathing new report into deaths of three people at Norfolk hospital

9th September 2021

LOCAL GOVERNMENT | NORFOLK

By Dan Grimmer
Public affairs correspondent
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A major investigation into the deaths of three vulnerable people at a private Norfolk hospital has revealed a string of failings, while police are looking into possible prosecution against those involved.

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TIMES INVESTIGATION

Oxfam in Haiti: 'It was like a Caligula orgy with prostitutes in Oxfam T-shirts'

Sean O'Neill, Chief Reporter

Friday February 09 2018, 12.01am, The Times

Oxfam

Nursing Times

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REVIEWS AND REPORTS

Francis Report: Timeline of Mid Staffs disaster

31 JANUARY, 2013 | BY SHAUN LINTERN

Shaun Lintern charts the sequence of events that led to the public inquiry into the well-publicised care failings at Mid Staffordshire Foundation

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13

- The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

Public Inquiry (2013) into Stafford Hospital

- There was felt to be an “endemic culture” of bullying at the Trust
- …all the executive team were in “a downward spiral of bullying and the inexperience (CEO, COO and Dir of Nursing) was creating a situation of a compete lack of leadership”
- “The nurses would go into that meeting and they were told in the meeting that [if] there were any breaches to – that is breaches of the four-hour rule – they would be in danger of losing their jobs. On a regular basis, and I mean a number of times per week, when I was on day shifts, I would see nurses coming out of that meeting crying”
- often present this sense of a very closed organisation, not listening and not welcoming external scrutiny, closed boards, no contact with any other hospital in the vicinity in terms of clinical networks and certainly not at all welcoming to any external organisation that wanted to come in and visit
- it was clearly thought instinctively by a senior employee of the Trust that an adverse report about care leading to a death should be suppressed, in part because of a fear of adverse publicity, and in part on a ground relating to family distress that can only be regarded as specious

Public Inquiry (2013) into Stafford Hospital (2)

“I have also heard evidence from staff about matters which give a picture of significant elements in the organisational culture:

- bullying
- target-driven priorities
- disengagement from management
- low staff morale
- isolation
- lack of candour acceptance of poor behaviours ……..”

Kirkup Report - Liverpool Community Health

- We heard from numerous members of staff that they were not listened to, that they were frightened to report issues, including bullying and harassment, and that they did not feel part of the decisions being made that shaped their area of service. These are consistent with the findings of the staff surveys at the time and should have been very worrying for the organisation and, in particular, for its Board.
- Staff approached Trust patient safety and incident reviews with trepidation. They were often blamed for incidents where the lack of qualified workers, proper supervision or expertise was the root cause. Error was not approached in an open and proportionate way. Mechanisms for managing patient safety and poor quality were based on blaming individuals, while organisational shortcomings were ignored or glossed over. Reporting of errors was seen as a slight on the external image of the Trust

Reading the Signals- Queen Elizabeth The Queen Mother Hospital at Margate and the William Harvey Hospital in Ashford,

- We have found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor

- One clinician told us that “many times we could have done better … the culture in obstetrics and the relationship with midwifery were poor”. An external assessor with wide experience of the NHS said that the Trust had “the worst culture I’ve ever seen”. Another, from a different organisation, had “not encountered such behaviour anywhere else”
- In a number of cases, the dysfunctional relationships between the staff involved were all too visible to the families themselves. This was such a common feature that we have concluded that it was part of the culture at QEQM and WHH

Winterbourne View (2011)

- There was clear management failure at the hospital – with no Registered Manager in place, substandard recruitment processes and limited staff training.
- There is no evidence that the written complaints of patients were addressed.
- Castlebeck Ltd's Human Resources Officers were aware of the breaches of patients' supervision requirements, concerns about under staffing and the misgivings of some staff concerning the use of restraint.
- ..inadequate staffing levels persisted with poor recruitment practices and further instances of unprofessional behaviour
- A 'closed and punitive' culture had developed – families and other visitors were not allowed access to the top floor wards and patient bedrooms, offering little chance for outsiders to see daily routines at the hospital.

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Wharlton Hall (2021)

- Staff members at Whorlton Hall had become immersed in a closed culture of abusive practices and a toxic culture that purposefully covered up the truth, while also actively misleading visiting agencies.

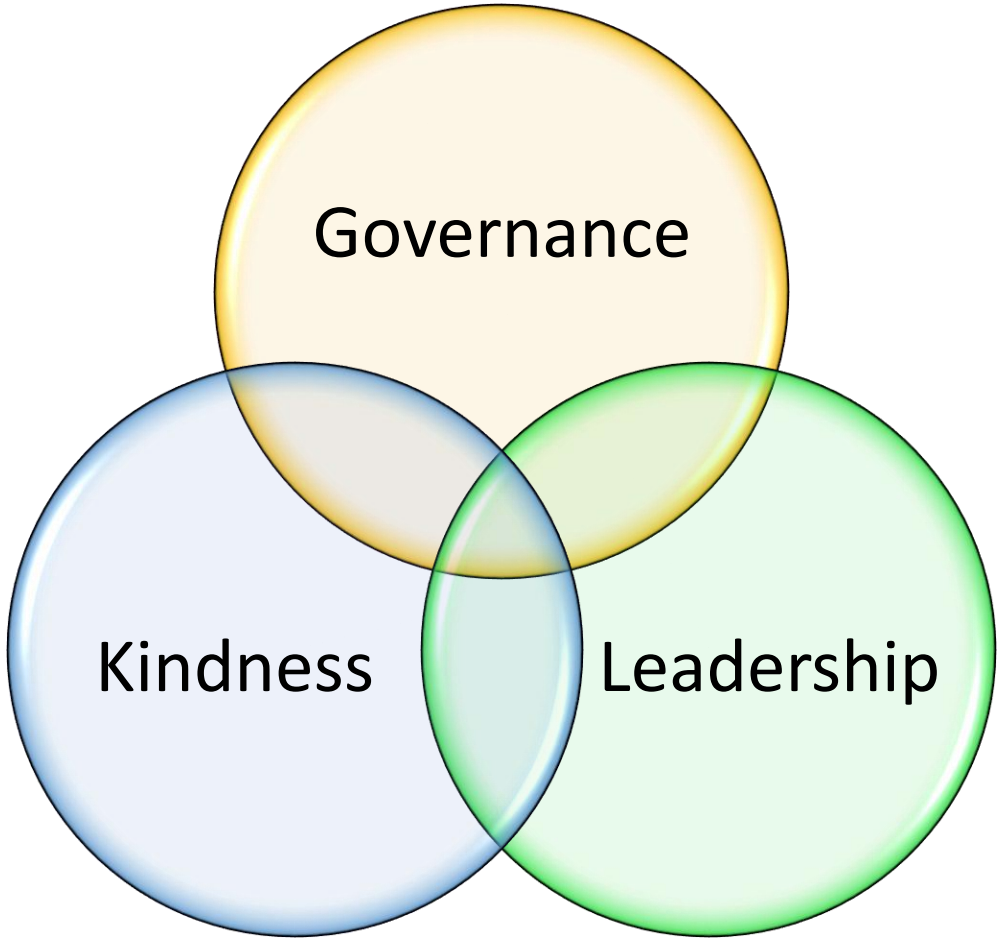
- Edenfield Unit (Prestwich Hospital…….

Joanna, Jon and Ben (Cawston Park)

- The Hospital is disadvantaged by the absence of accurate and timely information flowing up to managers and directors and down to staff and patients. Although first person accounts from patients and their relatives are powerful means of establishing the impact of a service and would provide a holistic view of performance, they are absent. Little may be discerned of the Hospital's corporate and financial governance or the extent to which this is intertwined with clinical governance
- Norfolk and Waveney CCG and Norfolk ASSD should review their commissioning arrangements to embrace "ethical commissioning
- "Ethical employment: Commissioners must be able to distinguish between the workforce practices of different providers and prioritise those acting as ethical employers…. This might include prioritising those companies that are accredited by the Living Wage Foundation; have effective training, development and supervision; sign up to an ethical care charter; outlaw false self-employment and zero-hours contracts; and encourage staff to participate in collective bargaining

Common themes

Creating Safer Organisational Cultures



Systems and compliance alone do not work: real, lasting, effective safeguarding is only achieved where safe cultures are prized.

Safe cultures only thrive where there is courageous and consistent leadership

The Civility Saves Lives campaign has highlighted that disrespect and rudeness create an environment where quality of work reduces, people are less likely to help each other and there are more errors as people are afraid to speak up and patients feel anxious

Kindness – the risk of incivility

What is incivility?
Incivility can be anything ranging from rude or unsociable speech or behaviour.

Importantly, it is as interpreted by the recipient.

There are many examples:

Shouting at someone, swearing, aggression (not necessarily towards someone), belittling someone, sending emails while in meetings, talking over others, being difficult over the phone, rolling eyes or tutting at someone. The list goes on

Kindness – The Impact of Incivility

This impact has a direct impact on the recipient, and this has been measured in the office place by Christine Porath. She found:

- 61% reduction in cognitive ability

There were also many other impacts:

- 80% lose time worrying about the rudeness
- 78% reduced their commitment to work
- 63% lose time avoiding the offender
- 48% reduced their time at work
- 38% reduce the quality of their work
- 25% took it out on others, including customers
- 12% leave

Kindness – the impact of incivility spreads to others

The impact spreads to others

The impact of rudeness spreads through a team like a ripple in a pond, impacting those who observe the rudeness too:

- 20% decrease in performance
- 50% reduction in willingness to help others

So it is affecting the function of others and their willing to work as a team.

It also impacts customers:

- 75% less enthusiasm for the organisation
- 66% feel anxious dealing with staff

This might prevent a patient asking staff for help, or reporting a symptom.

Governance has a place…….

- How is safeguarding embedded in our policies and procedures?
- How is safeguarding embedded in our code of conduct?
- Do our everyday practices reflect our policies, procedures and code of conduct?
- Are our policies and procedures up to date and relevant?
- How do we make sure our staff and volunteers are all contributing to keeping people safe?
- How do we challenge ourselves when we're worried about safeguarding?

Culture eats strategy – and codes of conduct too

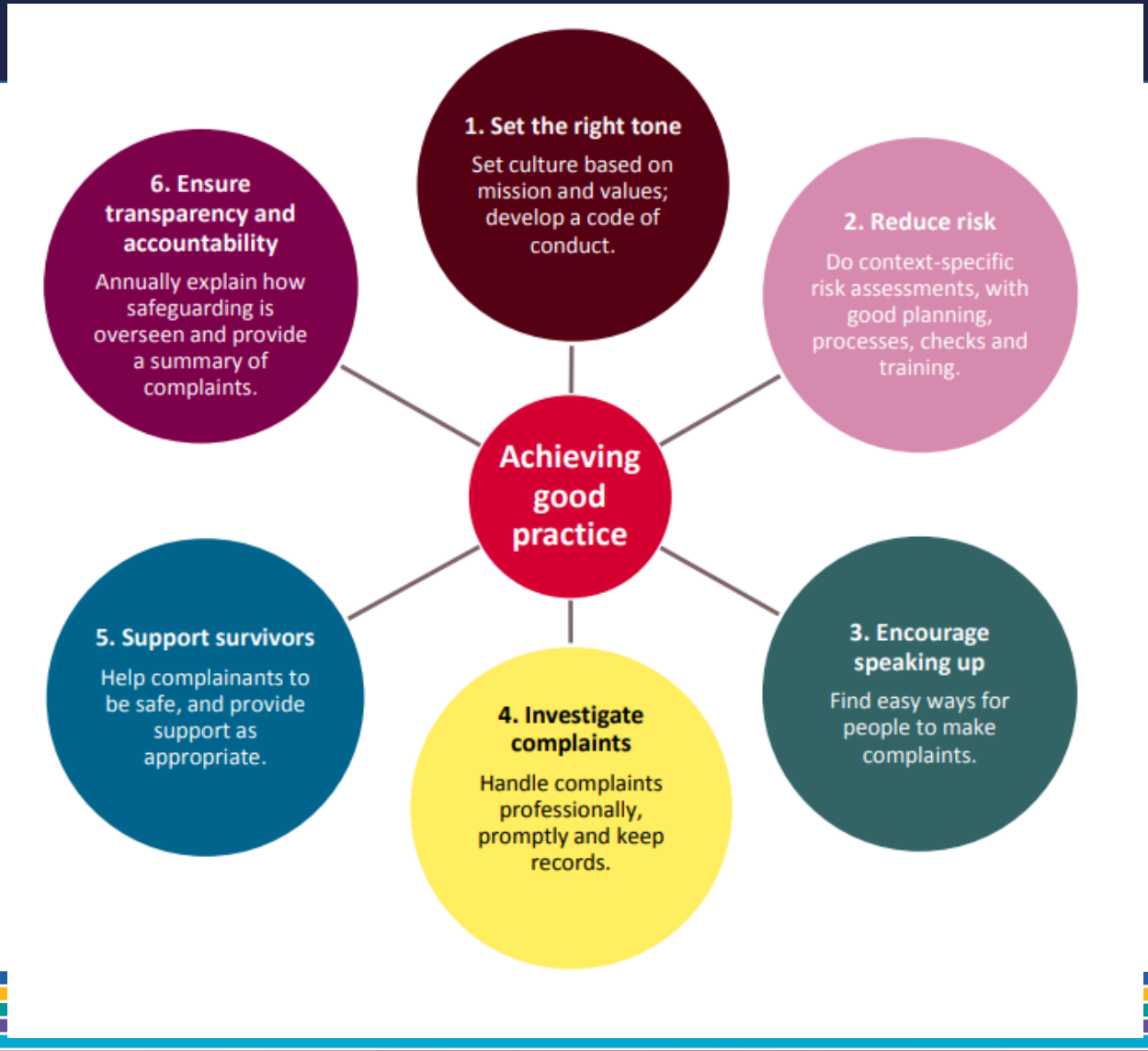
Do I encourage a safer organisational culture in what I say and do?

Listen
An environment where everyone is confident their concerns are welcomed, listened to and addressed appropriately.

Learn
Where organisations encourage continuous learning and reflection at all levels. Applying this to improve and adapt.

Lead
Organisations should lead by example to empower everyone with the confidence to challenge and instigate change.

Creating Safer Organisational Cultures (Bond)



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- https://www.civilitysaveslives.com/
- https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/civility-and-respect/
- Leading with values: creating a safe organisational culture https://www.acevo.org.uk/wp-content/uploads/2019/07/Leading-with-values.pdf
- **Joanna, "Jon" and Ben https://www.norfolksafeguardingadultsboard.info/publications-info-resources/safeguarding-adults-reviews/joanna-jon-and-ben-published-september-2021/**
- **https://www.bond.org.uk/resources/good-governance-for-safeguarding-a-guide-for-uk-ngo-boards/**
- **Winterbourne View A Summary of the Governments Response**
- **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary**
- **Reading the signals Maternity and neonatal services in East Kent**
- **Report of the Liverpool Community Health Independent Review**