The **Regulation** and
Quality Improvement
Authority

Cherry Lodge Children's Home

Independent Review into Safe and Effective Respite Care for Children and Young People with Disabilities

September 2007

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Summary

What this report is about

This review concentrated on one small respite unit for children with complex disabilities. The service provided in the unit was highly valued by families and well regarded by professional staff. Following an untoward incident in the unit in June 2006, the Regulation and Quality Improvement Authority (RQIA) decided to review the circumstances surrounding the incident. RQIA asked us - an independent Review Panel to carry out the review.

The untoward incident took place in Cherry Lodge Children's Home, a three-bed respite home run by Barnardo's (NI) in Randalstown, County Antrim.

During a weekend stay, an 18-year-old young person (Y) sustained extensive bruising to both hands and arms. A police investigation began on 5 July 2006. At the time of writing, the outcome of the police investigation was unknown. A file on the case was sent to the Public Prosecution Service on 21 March 2007.

RQIA's decision to ask us to undertake the review reflected concerns about how the home was safeguarding young people. These concerns were raised by RQIA following their initial examination of the events surrounding the incident described above. It also reflected growing uncertainty by the various agencies involved about how effectively Cherry Lodge was being run.

Since we carried out our review, and while compiling our final report, we learned that Cherry Lodge temporarily stopped operating in January 2007.

This summary outlines:

- **Who we are**
- **The incident we were asked to review**
- **How we carried out our review**
- **What our review found**
- **Our recommendations**

We carried out a complex and thorough review of all the circumstances. This summary covers the main points of our review.

Who we are

Our Panel includes experienced people from paediatrics, social work, learning disabilities and inspection. We are all independent of the main organisations responsible for commissioning, running and monitoring Cherry Lodge.

The review was started in September 2006, before the re-organisation of Health and Social Services in Northern Ireland. The names of organisations referred to in the report are therefore those that were in place before April 2007.

The incident we were asked to review

During the weekend of Friday 23 June to Sunday 25 June 2006, a young person, who we will refer to as Y in this report, was admitted to Cherry Lodge for respite care. This would not normally have happened as the unit is only registered to take children up to the age of eighteen, but there was no other place available. Y had been coming to Cherry Lodge for respite for eight years and it was intended that this would be Y's last stay before moving on to adult services for respite.

Records from the weekend show that the young person sustained extensive bruising to both hands and arms.

Our main report details what happened in the next few days, including:

- how the bruising was formally reported to the on-call designated manager from Barnardo's on the Sunday evening;
- when Y's father was informed of the bruising;
- how Y was not medically examined until the day after the bruising was reported;
- how doctors subsequently suggested the bruising may have been caused by some form of restraint;
- how no suitably qualified or experienced paediatrician in forensic procedures was available in Homefirst Trust to examine Y; and
- what measures were put in place so that the Cherry Lodge service could safely continue.

We were not asked to re-investigate the incident. Rather, our task was to:

- consider how Cherry Lodge's respite services were being commissioned, run, delivered and monitored;
- consider what could have contributed to the incident;
- review the procedures and practice in response to the incident;
- consider what needed to be in place to deliver safe and effective care for such a group of vulnerable children and young people;
- identify any improvements that we thought that the service needed; and
- identify any improvements that could be made by the organisations involved in commissioning, monitoring, delivering and regulating children's and young people's services.

How we carried out our review

Each organisation involved with Cherry Lodge was asked to give us details to help with our review. They were:

- **Homefirst Trust,** which provides health and social services; it also secures and pays for services from organisations, such as Barnardo's. (The Trust is now part of the Northern Health and Social Care Trust).

- **Barnardo's,** a voluntary organisation that provides services to vulnerable children and their families through projects at home, school and in local communities.
- **The Northern Health and Social Services Board,** which during the period under review was responsible for assessing health and social care needs of local people and planning, securing and paying for services from organisations and agencies such as Homefirst Trust.

Our main report has full details on the information we received and what we did with it. It also details the other people and organisations we asked for information during our review.

During our review we:

- invited, through Barnardo's, all members of staff for Cherry Lodge, past and present, to contribute to the review (they could do so anonymously);
- sent letters to employees of the other organisations involved, inviting them to contribute;
- met, at their request, with managers and staff from some of the organisations concerned;
- asked parents what they thought about the quality of the services provided to them and their children by the organisations involved;
- contacted and interviewed the parents of Y to obtain their views on the incident: and
- spent some time with Y.

We also reviewed:

- the procedures and practices for planning, monitoring and reviewing care for children placed at Cherry Lodge;
- the quality of care and safeguarding of children at Cherry Lodge, including staffing and training issues;
- how services at Cherry Lodge were monitored;
- how standards of care for children with disabilities when they are accommodated for respite met the legal requirements[1], including the United Nations Convention on the Rights of the Child[2]; and
- the structures, processes, roles and responsibilities that various organisations involved in caring for children in respite had in place to enable them to provide good quality services, monitor these and improve them.

[1] Under Article 25 of the Children (Northern Ireland) Order 1995, a child is "looked after" by a Trust if the child is in the Trust's care *(i.e. under a Court Order)* or is provided with accommodation for a continuous period of more than 24 hours by the Trust. Cherry Lodge is a registered children's home which provides residential respite care. Children who receive this service, whilst not in the care of the Trust are, nevertheless, provided with accommodation in the home by the Trust. They therefore come within the full regulatory provisions of the Children Order insofar as these relate to "looked after" children in a residential setting

[2] The UNCRC can be accessed at: http://www.ohchr.org/english/law/crc.htm

What our review found

We found that the service provided by Cherry Lodge was highly regarded by parents and professionals alike. But the untoward incident exposed weaknesses in many procedures and systems. Our detailed review found the following:

- Some front-line staff in Cherry Lodge had been concerned for some time about deteriorating standards of practice in the unit.

- Good systems and structures were in place for monitoring quality, but external managers and other stakeholders, including RQIA, did not ask enough searching questions about the quality of care.

- All staff and agencies involved in delivering respite at Cherry Lodge were doing their best to provide a service that families found invaluable and children enjoyed. However, the Review Panel formed the view, based on information received from Barnardo's and Homefirst, that a shift from the original service, which mainly provided day services, to a seven-day residential facility was not managed or monitored in a way that ensured that staff were sufficiently trained and services appropriately monitored to protect the children.

- Cherry Lodge had acute staff relationship problems, had lost experienced staff and was using more temporary and relief staff.

- Managers focused on making sure services continued to be delivered, rather than considering the potential build-up of risks to some very vulnerable children with complex needs. It is now clear more fundamental questions needed to be asked about the quality of the service when acute staff problems were identified in late 2005.

- Evidence that Articles 2, 12 and 23 of the UN Convention on the Rights of the Child were not being complied with. The agencies we reviewed did not hear or fully respect the rights of the children and young people. Some of the children and young people in Cherry Lodge were able to express their views with assistance but were not offered any access to independent advocacy: that is, to someone who could help them speak up. We thought that this kind of arrangement would have helped the agencies to listen to the children's views.

- Families had little idea of the role, purpose and function of the different organisations who provide a service to disabled children.

- More consultation by RQIA would have given parents and children an opportunity to better understand its role as regulator. This would also have given them an independent way to raise any concerns and complaints quickly.

- The children admitted to Cherry Lodge were not in the "care of the Trust" in the sense that they lived with their families who retained parental responsibility for them. Nevertheless most of them had very complex needs and were

accommodated by the Trust in Cherry Lodge, bringing them under the provisions of the Children Order as "looked after children" in a residential setting.

- There were deficits in each organisation's accountability and management arrangements for monitoring, auditing and quality assuring the service at Cherry Lodge.

We could not state with certainty that an earlier management review would have prevented the June 2006 incident. What was very clear, however, was that the response to the incident would have been much more disciplined and better managed if the organisations involved had had better arrangements in place:

- for supervising, managing and recording practice; and
- for implementing policy and procedures.

We also believe that these better arrangements would have reduced the risk of such an incident occurring in the first place.

An important learning point from this review is that all organisations must continuously and vigorously challenge the routine information they receive and not always take it at face value.

In particular, Barnardo's and Homefirst Trust should undertake a full assessment of all members of staff who were on duty that weekend to determine their need for supervision and training. Such an assessment will have to take into account employees' rights and assurance should be given to the families who have used and hope to use Cherry Lodge in the future.

Our recommendations

Following receipt of this review, it will be the responsibility of RQIA to make decisions about how the learning and action points and the recommendations will be taken forward.

At the end of each chapter, we have listed detailed points for action and have highlighted areas for self-assessment for each organisation covered by the Review.

Below, we have made summary recommendations for all organisations who commission, deliver and monitor respite care for children with disabilities. We divided our recommendations into those that need to be addressed immediately (called Priority 1 Recommendations) and those that need to be addressed in the short to medium term (Priority 2).

The Priority 1 Recommendations asked that those who make decisions about where children are placed for respite, ensure that all the professionals who are involved with a child, contribute to the assessment process. It has been recommended that after the assessment is completed, careful consideration is given to whether the child's needs can be met by a particular service.

The Department of Health Social Services and Public Safety (DHSSPS) has been asked to do two things. Firstly, to clarify guidance about when to apply Looked After Children Guidance for children with disabilities who are accommodated when receiving respite services. Secondly, the DHSSPS has been asked to review the new care standards that are currently in draft form. This review is to ensure that the standards reflect current thinking about meeting the needs of children with disabilities and that they comply with the relevant Articles of the UN Convention on the Rights of the Child.

Directors in Trusts and Boards have a responsibility as corporate parents for children who are accommodated. We wanted to make sure that all directors understand their responsibilities in relation to children with disabilities when they are accommodated for respite. We also recommended that corporate parenting reports and any other overview mechanisms include services for children with disabilities who are accommodated.

We recommended that organisations who provide services for children with disabilities make sure that their staff receive regular training in child protection and, where appropriate vulnerable adults procedures. The training should be monitored and reviewed regularly. This recommendation is in keeping with those made by the Social Services Inspectorate at DHSSPS in a recent report on child protection[3].

In the Priority 1 Recommendations, we stated that all organisations providing services for children with disabilities should ensure that they have the appropriate policies and procedures in place to meet the specific needs of disabled children and that they carry out audits of how staff work to ensure that policies and procedures are being adhered to, for example, how medicines are administered and how challenging behaviour is managed.

We recommended that Barnardo's and Homefirst Trust undertake risk assessments, support and supervision plans for all staff who were on duty during the weekend of 23 – 25 June 2006 and provide assurance to families whose children have used and will use Cherry Lodge in the future.

Finally, we asked RQIA to review over the next three years how well their monitoring systems are working for respite services for children with disabilities.

In our Priority 2 Recommendations, we asked that:

- every effort is made to obtain the views of children and young people and their families when assessments are being carried out, care plans are being developed and reviews are taking place.

[3] Our Children and Young People - Our Shared Responsibility, Inspection of Child Protection Services in Northern Ireland, Social Services Inspectorate, DHSSPS, December 2006. It can be accessed at: http://www.dhsspsni.gov.uk/oss-child-protection.htm

- Trusts check that work undertaken by social workers complies with the legal requirements for Looked After Children. Trusts should also make sure that the Codes of Practice[4] produced by the Northern Ireland Social Care Council are fully understood and incorporated into everyday work and management systems.

- all organisations examine how information and reporting systems are used at all levels to influence quality and improve services.

- RQIA consider implementing a system that would enable an individual child to be tracked as he or she uses services. This would assist in monitoring standards of care and making recommendations for improvements.

- RQIA agree with the new Trusts and with the Strategic Health and Social Services Authority how best to share information from investigations and reviews.

- all organisations providing services ensure that a system is in place that enables staff to openly raise concerns. This is often called a whistleblowing policy. We also asked that organisations make sure that a management review and an action plan is developed quickly, following use of the whistleblowing policy by staff.

[4] Codes of Practice for Social Care Workers and Employers of Social Care Workers, Northern Ireland Social Care Council, September 2002

Chapter 1: Introduction

This chapter provides background information to the review that we – the Review Panel – carried out into Cherry Lodge Children's Home. It explains:

- **About us**
- **Our remit and terms of reference**
- **Our appointment, roles and responsibilities**
- **Our advisors and peer reviewers**
- **How we defined and set about our task**
- **Our approach in general**
- **Our methodology**
- **How we reviewed services provided at Cherry Lodge**
- **How we sought comments from staff**
- **How we reviewed information received from Homefirst Trust**
- **How we reviewed information received from the NHSSB**
- **How we reviewed information received from RQIA**
- **How we reviewed information received from parents**
- **The legal background to our review**

About us

We were appointed as a Review Panel by the RQIA Board to review the circumstances surrounding the untoward incident at Cherry Lodge in June 2006. Full details of the incident are in chapter 2 of this report.

The RQIA Board's decision to seek a review reflected the incident and concerns about how the home was safeguarding young people. It also reflected uncertainty, following the incident, by the various agencies involved, about how effectively Cherry Lodge was being run.

Our members were:

- Jacquie Roberts, Chief Executive, Care Commission, Scotland (Independent Chair)
- Terry Beecham, Senior Inspector, Care Standards Inspectorate for Wales
- Dr Sandi Hutton, Consultant Paediatrician, Foyle Trust
- Jacqui McGarvey, Programme Manager, South and East Belfast Trust
- Barney McNeany, Interim Commissioner and Chief Executive, Northern Ireland Commission for Children and Young People
- Miriam Somerville, Director of Hospital and Community Learning Disability Services, North and West Belfast Trust

Our remit and terms of reference

Our remit was not to re-investigate the incident. Rather it was to consider wider issues of how Cherry Lodge's respite services were being commissioned, run, delivered and monitored. It was also to identify any improvements that the service needed.

In carrying out our review we also considered how the Northern Health and Social Services Board (NHSSB), Homefirst Trust and Barnardo's fulfilled the principles of, and upheld the standards linked to, valuing and promoting the rights of children under the UN Convention on the Rights of the Child. (Appendix 1 lists relevant Articles from the Convention).

The RQIA Board set out our terms of reference in September 2006. These were to:

- review how Barnardo's and Homefirst Trust implement policy, procedures and practice on child protection and vulnerable adults;

- review current practices and ensure that children's and young people's rights and best interests are upheld:

  - when Homefirst Trust assesses children and young people for admission to Cherry Lodge, plan their care and assess their placement; and
  - in relation to the quality of care and safeguarding that Barnardo's provide children and young people who are placed in this unit;

- investigate any other governance or regulatory issues concerning Cherry Lodge that involve the Northern Health and Social Services Board, Homefirst Trust, Barnardo's, and RQIA; and

- establish if lessons need to be learned from the case, provide a report and recommend how to improve quality, as required, to the Department of Health and Social Services and Public Safety (DHSSPS).

The Review Panel agreed that it should aim to make recommendations that would be positive and constructive for the children and young people who received respite at Cherry Lodge. We were also asked to pass on any service improvements that we identified to the agencies responsible for commissioning, monitoring, delivering and regulating children's and young people's services.

Our review was in line with the terms of the Children (Northern Ireland) Order 1995[5] and the Quality Standards for Health and Social Care - Supporting Good Governance and Best Practice in the Health and Personal Social Services, March 2006[6].

[5] The Children (Northern Ireland) Order 1995 can be accessed at:
http:/www.opsi.gov.uk/si/si1995/Uksi_19950755_en1.htm#tcon
The Explanatory Note can be accessed at:
http://www.opsi.gov.uk/si/si1995/Uksi_19950755_en_55.htm#exnote

[6] The Quality Standards for Health and Social Care can be accessed at:
http:www.dhsspsni.gov.uk/qpi_quality_standards_for_health__social_care.pdf

Our appointment, roles and responsibilities

Before the Review, the Chief Executive of RQIA sent a letter to the Chief Executive of the NHSSB, Homefirst Trust and Director of Barnardo's (NI) informing them of RQIA's intention to commission an independent review of the Cherry Lodge service.

Each agency was given details of the Panel's members and their terms of reference and was asked to submit a range of information to the RQIA. Appendices 2, 3 and 4 list this information. It was received on 27 October 2006 and submitted to Jacquie Roberts, Chief Executive of the Care Commission in Scotland. The RQIA had asked Ms Roberts to chair the Review Panel.

The Panel's members included current practitioners with paediatric, social work, learning disabilities and inspection expertise, all independent from the main agencies concerned. Further details about Panel members can be seen in Appendix 5.

Our advisors and peer reviewers

We used a peer review approach: that is, review by people with expertise and experience of a service, but who are not involved in providing it in the area that is being reviewed. This is in keeping with how RQIA carries out social and clinical governance reviews, although, on this occasion, no lay person was sought as it was mainly a paper-based review.

The Interim Commissioner and Chief Executive of the Northern Ireland Commissioner for Children and Young People (NICCY) from March 2006 participated fully.

The Review Panel also had help from the Director of Social Services in RQIA. The Director undertook a co-ordinating and administrative role and oversaw and co-ordinated data collected during the review, kept links with all the bodies identified by the review and responded to any regulatory issues that arose during the review. RQIA provided administrative help.

Three peer reviewers were recruited by RQIA to be Panel members between September 2006 and October 2006.

It was agreed that four RQIA inspectors who were not involved with Cherry Lodge before 30 July 2006 would be specialist advisors to the Panel. They were two nurse inspectors, one pharmacy inspector and one care inspector.

As the respite services at Cherry Lodge were continuing, a parallel inspection and safeguarding process had to continue, and additional safeguards were put in place, to ensure that children were being cared for safely and effectively during the review period.

As our first formal Review Panel meeting could not take place until 27 October 2006, the four RQIA specialist advisors met Ms Roberts on 22 September 2006. It was agreed that they would audit the files of eight children who had complex needs and who were placed for respite in Cherry Lodge between 1 August 2005 and 1 August

2006. This audit was to gather evidence from a sample of the practices used in reporting incidents, managing medication and care planning, during the twelve months in which the incident occurred. The inspectors would review this information against the current standards expected of the home. These standards are referenced in the relevant chapters.

It was agreed that we could consider the findings of this audit when we analysed evidence of practice in the home, without having to replicate this information-gathering. Ms Roberts agreed to share this information with the Panel at its first formal meeting on 27 October 2006.

How we defined and set about our task

This section considers:

- Our approach in general
- Our methodology
- How we reviewed services provided at Cherry Lodge
- How we sought comments from staff
- How we reviewed information received from Homefirst Trust
- How we reviewed information received from RQIA; and
- How we reviewed information received from parents

Our approach in general

The approach we adopted was to recognise that all the agencies concerned shared responsibility for delivering care safely and effectively at Cherry Lodge. Our aim was to identify important lessons that everyone in the system could take on board.

Our Review extended beyond the immediate circumstances of the incident for two main reasons:

- Although the review had been brought about by a worrying incident of unexplained injuries, it soon became clear from early evidence from RQIA inspectors that there were gaps in the arrangements for commissioning, delivering and monitoring this respite service.

- By asking initially what might have been done differently to prevent the incident and what lessons had been learnt, the Panel formed the view that our recommendations would apply more generally to commissioning, designing, delivering and monitoring of any quality respite care service for children with disabilities.

Our findings and recommendations are based on an analysis of the range of interview and documentary information provided to the Review Panel by the individuals and organisations concerned.

To help us build up a comprehensive picture of the service at Cherry Lodge, we reviewed evidence submitted by Barnardo's staff and reports from the various

agencies. The considerable amount of documentation we received was on the understanding that individuals' privacy and confidentiality would be protected as far as possible in the final report.

Our methodology

To assess the quality of each agency's service we developed a framework or grid of standards, expectations and practice that we would expect to find, and used this as a basis for analysing the information submitted to us. This grid is available from RQIA on request.

How we reviewed services provided at Cherry Lodge

We used evidence from the audits by the four specialist advisors and from two of the peer reviewers. This helped us form an overview of residential care practice in Barnardo's and enabled us to comment on the quality of care and safeguarding in Cherry Lodge during the review period.

The audit included assessing how Barnardo's:

- planned admissions;
- planned and reviewed the care it provided; and
- assessed risks.

We reviewed the extent of Barnardo's liaison with the social workers from Homefirst Trust who placed children in Cherry Lodge. In particular we considered:

- how pre-admission assessments were completed; and
- the attention given to managing the care, healthcare, child protection needs and behaviour of the eight children and young people whose files were audited.

The audit included an overview of the medication records and of the reports into the June 2006 incident that Barnardo's recorded and sent to other agencies.

We also scrutinised information about management, supervision and monitoring by Barnardo's.

How we sought comments from staff

We invited all members of staff for Cherry Lodge, past and present, to contribute. They could do so anonymously.

Four responded in writing and five attended a meeting with some Panel members. We have taken all contributions into account. As some staff members were still subject to disciplinary procedures, we took care to avoid becoming involved in matters of employer-employee relationships.

We sent letters to employees of the other external agencies involved inviting them to contribute or share any information. Although we received no comments from the

staff of other agencies, we met with senior managers from Barnardo's and Homefirst Trust who asked to meet with the Panel. A response was received from the former inspector for the service.

How we reviewed information received from Homefirst Trust

We reviewed all the information submitted by the Chief Executive of Homefirst Trust including the:

- contract with Barnardo's;
- monitoring and governance processes for reviewing this service; and
- reporting of how they discharged their legal duties to the NHSSB.

The social work peer reviewer audited the same eight fieldwork care files that the RQIA specialist advisors had audited. The peer reviewer concentrated on the Trust's fieldwork practices for:

- how the Trust assessed the needs and planned the admission of children;
- care planning;
- reviewing children's cases;
- managing risks; and
- protecting children.

The paediatric peer reviewer concentrated on the Trust's record-keeping and how it met the children's healthcare and protection needs.

How we reviewed information received from the NHSSB

We received extensive documents from the Board. We reviewed these, giving particular consideration to how the Board commissions respite services and its processes for monitoring Homefirst Trust, to whom it has delegated important legally binding childcare and adult care functions.

How we reviewed information received from the RQIA

A senior inspector from the Care Standards Inspectorate for Wales reviewed the RQIA's inspection records and regulatory processes from 1 August 2005 to 1 August 2006. The inspector compared this evidence to the practice that care inspectors in Wales are expected to meet. Ms Roberts added comments in this area based on her knowledge of how care services are regulated and delivered in Scotland.

How we reviewed information received from parents

We sent a letter through Homefirst Trust on 8 November 2006 to all parents of children and young people under eighteen years who had been at Cherry Lodge between 1 August 2005 and 1 August 2006. We wanted to know what parents thought about the quality of the services provided to them and their children by the organisations involved.

In addition, during our Review, parents:

- wrote to us;
- spoke to some of our members on the phone; and
- attended a meeting we set up. The notes of this meeting can be seen in Appendix 6.

We were struck by the strength of feeling about how important these services were to these families. These are some of the written statements they made about Cherry Lodge:

> "The service provided by Cherry Lodge allows me to recharge my batteries and for my son to spend time with children like himself in a home-from-home environment with very caring staff who can care for him just as I would."
>
> "Cherry Lodge has been and is our lifeline."
>
> "When we brought my son from home to Cherry Lodge, he was happy to go."
>
> "The care and commitment of staff over these years has always been excellent and our son loves his time at Cherry Lodge."
>
> "I never had any doubts as I trusted everyone in Cherry Lodge."
>
> "I don't want Cherry Lodge to close; it is valuable to me."

We contacted and met with the parents and the young person who sustained injuries to obtain their views on the incident. This was before finalising our report, to clarify some conflicting pieces of information presented to us.

The legal background to our review

The RQIA Board sought the review:

- as a result of the incident;
- out of concern about safeguarding young people at Cherry Lodge; and
- due to uncertainty about the robustness of the structures, processes, roles and responsibilities put in place by the various agencies to provide and monitor good quality services.

By commissioning the Review, RQIA was pursuing its legal functions set out in Part IV, Article 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 of "conducting reviews and making reports on, arrangements by statutory bodies for the purpose of monitoring and improving the quality of health and personal social services for which they have responsibility"[7].

[7] The 2003 Order can be accessed at: http://www.opsi.gov.uk/si/si2003/20030431.htm
The Explanatory Memorandum to the 2003 Order can be accessed at:
http//www.opsi.gov.uk/si/si2003/03em0431.htm

This law also:

- places a duty of quality on Health and Personal Social Services (HPSS), now Health and Social Care organisations;
- sets the standards for providing good quality care services; and
- sets out how organisations are accountable for continuously improving and maintaining the quality of services, care and treatment they provide.

Chapter 2: The untoward incident of June 2006

This chapter considers the incident that led to this Review. It has the following sections:

- **Our remit and approach**
- **The incident which occurred during the weekend of Friday 23 June - Sunday 25 June 2006**
- **Monday 26 June 2006: what happened after the incident**
- **Tuesday 27 June 2006: social work and medical responses**
- **Wednesday 28 June 2006: strategy meeting**
- **Interim measures to safeguard children in Cherry Lodge**
- **The police investigation**

Our recommended points for action and self-assessment are at the end of the chapter.

Our remit and approach

We wished to respect the young person's privacy and confidentiality as much as possible and have tried to avoid any specific details that would identify the young person. We will refer to the young person as Y. Our remit, with respect to the incident, was to:

- ask what could have contributed to the incident;
- review the procedures and practice in response to the incident; and
- ask what needed to be in place to deliver safe and effective care for such a group of vulnerable children and young people.

The answer to these questions became more apparent as our review of practice unfolded across the different agencies. However, our starting point was to review the known details of the incident. It has been extremely difficult to piece together an accurate account: there are still differing interpretations of events by different people. The following is the Review Panel's summary of what happened, based on the records available and the family's account.

The incident which occurred during the weekend of Friday 23 June - Sunday 25 June 2006

During the weekend of Friday 23 June to Sunday 25 June 2006, three young people, including Y were admitted to Cherry Lodge for respite. On Sunday, a further two young people were admitted for day care. The children's ages ranged from six years to eighteen years.

Y had just had an eighteenth birthday and therefore fell outside Cherry Lodge's admission criteria. Y had been receiving respite at Cherry Lodge for eight years and as no immediate alternative respite care placement was available from Homefirst Trust for the family, Barnardo's and RQIA agreed – exceptionally – to a short-term admission.

That weekend, a minimum of four staff were on duty during the day and two staff were on duty at night to meet the needs of the children and young people placed for respite care.

A member of Cherry Lodge staff telephoned the on-call designated manager on Friday and later on Saturday evening about Y's unsettled and self-abusive behaviour. It is not clear from the Barnardo's records, what action was taken by staff to respond to this problem, to inform the parents, or if any bruising or injuries were seen at that stage.

Next it is recorded that on Sunday 25 June, Y sustained extensive bruising to both hands and arms. This bruising was formally reported to the on-call designated manager Barnardo's on the Sunday evening.

Information in a report submitted by Barnardo's to the Panel indicated that a member of staff recollected bruising on Y's wrists on Friday 23 June 2006 when Y arrived for the weekend stay. A bruise chart was prepared retrospectively by that staff member.

The Police Service of Northern Ireland (PSNI) has not been able to verify this recollection and has carried out its investigation on the assumption that the significant bruising occurred some time between Saturday 24 June 2006 and when it was reported at 9.25 pm on Sunday 25 June 2006.

An on-call designated manager for Cherry Lodge spoke by telephone to Y's father at 10.30 pm on Sunday 25 June 2006. The father was told that Y had been self-abusive and had suffered bruising to the left hand. In this conversation the staff member did discuss taking Y to Accident and Emergency. According to the report received from Barnardo's, the staff member told the father that Y was able to move their fingers and did not appear distressed when their hands were touched.

The father disputes this record of the conversation; he reported to the Review Panel that the full extent and severity of the bruising were not made clear to him. He said he would take Y home if desired, but he was assured by Cherry Lodge staff that they were happy to continue to provide respite care as planned until the following morning.

After talking to the father the staff member decided not to take Y for a medical examination.

Another staff member completed a bruise chart on Sunday 25 June 2006 detailing the extent of the bruises. The report that Barnardo's management submitted to us indicated concerns about the formal recording by their staff of observations of bruising. It indicated concern that recording the bruises on the bruise charts was confusing in terms of their timing and the dates for that weekend.

Whilst Barnardo's staff may not have been aware of adult protection procedures, the organisation had a child protection procedure in place that all residential staff should have followed if an unexplained injury occurred during respite in a children's home. This procedure makes it clear that any concerns about a child must be reported immediately to a Trust social worker and telephone numbers are included for both

daytime and out-of-hours assistance. Barnardo's staff had access to this procedure during the weekend in question. An emergency out-of-hours social worker was available but was not pursued by Barnardo's. The Regional Child Protection Policies and Procedures[8] also make it clear that child protection concerns must be referred immediately. Given the extent of the bruising, it was the view of the Review Panel, that it would have been a reasonable expectation and in keeping with Barnardo's own procedures, to make a referral to the out-of-hours social worker, if only for advice.

Monday 26 June 2006: what happened after the incident

On Monday 26 June 2006 a member of Cherry Lodge staff took Y to school and told school staff about the bruising. The school principal subsequently telephoned Cherry Lodge to express her concern about the extent of the bruising and to seek an explanation. She was told about Y's self-abusing behaviour over the weekend.

There is no record of Barnardo's contacting Y's mother on Monday 26 June 2006 to inform her of the bruising. At 3.00 pm that day a special support classroom assistant at the school contacted the mother and told her about the nature of Y's bruising. Barnardo's staff reported that they had had to sit with Y for much of the night with ice packs on the bruised hand. The mother confirmed that the principal told her that Barnardo's staff had said that they had to sit with Y. The mother arranged for an immediate examination of the injuries at the Accident and Emergency Department at the Mid-Ulster Hospital in Magherafelt. According to Y's mother, the registrar on duty described the injuries as suspicious and not consistent with self-abusing behaviour and suggested some form of restraint may have been applied.

The mother reported to us that she had contacted Cherry Lodge earlier in the day and reported to Review Panel members that no reference was made to any injury sustained by Y.

Barnardo's records indicated that they contacted Homefirst Trust to inform them about Y's injury that afternoon.

Tuesday 27 June 2006: social work and medical responses

On Tuesday 27 June 2006 Y's mother contacted a social worker in Homefirst Trust to discuss her concerns. The social worker arranged for Y to be seen by a consultant psychiatrist. This doctor also suggested to Y's mother that the bruising may have been caused by some form of restraint. This information was shared with social services who advised the mother to bring Y to her general practitioner. The GP also expressed a view that the bruising was consistent with some form of restraint. The social worker told her senior social worker about these concerns and a strategy meeting was arranged under the Protection of Vulnerable Adults Procedures for the next day to review the matter.

[8] Area Child Protection Committees' Regional Policy and Procedures, Northern Ireland, 2005. The ACPC Regional Policy and Procedures can be accessed at: http://www.childrensservicesni.co.uk

Wednesday 28 June 2006: strategy meeting

At the strategy meeting, the mother showed photographs she had taken to show the nature and extent of the bruising. The PSNI was not present at this meeting.

A significant difficulty was noted at the meeting when the group of people present – who represented various agencies – suggested a further medical examination by a paediatric consultant with expertise in child protection work should be undertaken, provided the parent agreed. The parent did agree. However, no suitably qualified or experienced paediatrician in forensic procedures was available in Homefirst Trust to carry out such an examination. Because of Y's age, there was some debate about whether or not child protection procedures were appropriate.

There is no clear guideline for paediatricians examining children over 16 years, as they do not normally medically examine children over 16 years. Doctors use discretion, however, in relation to adolescents with complex disability, and it would not be unreasonable for a paediatrician with expertise in child protection to be asked to examine a young person over 16 years of age in these circumstances. It is not clear to what extent consideration was given to Y giving consent on her own behalf.

The social worker contacted a community paediatrician who felt that, given the time that had elapsed from the beginning of the week, no further useful information would result. No further medical examination took place.

At the strategy meeting, the family was asked to consider making a complaint to the PSNI. The mother said that she found it extremely difficult to find fault or blame with a service that had offered her family such a level of support over the years. But those present at the meeting said that, under vulnerable adult procedures, social services staff had to inform the PSNI so they could investigate.

The parents appear to have been given some time by Homefirst Trust to consider making their own complaint to the PSNI. Although it is good practice to ensure that a family is aware that they are able to make their own complaint to the PSNI, the way in which this is presented needs to be handled carefully. In the Review Panel's view, this discussion resulted in an unfair and unnecessary burden of responsibility being placed on the parents, as the Trust were already making this decision in view of the information available and Y's age and vulnerability under the Trust's policy and procedures for protecting vulnerable adults.

Those in attendance at the meeting decided that an investigation should be jointly conducted involving two RQIA inspectors and a senior manager from Homefirst Trust. The minutes of the meeting reflect a lack of clarity about the responsibilities of both the Trust and RQIA in the investigation of the incident and a lack of knowledge about the Protocol for Joint Investigation contained in Protection of Vulnerable Adults Procedures. This decision was to be reviewed again by the Trust on Friday 30 June 2006.

Interim measures to safeguard children in Cherry Lodge

A safeguarding process was put in place by Homefirst Trust, Barnardo's and RQIA.

This was aimed at ensuring that safeguards and improvements in practices were in place so that the Cherry Lodge service could safely continue. RQIA stepped up monitoring arrangements for the service. Homefirst Trust and Barnardo's held weekly monitoring meetings and shared the minutes with the RQIA care inspector for the unit. Homefirst Trust and Barnardo's allocated extra staff to the home. Additional training and development were arranged for all Barnardo's staff. No new admissions were to be accepted.

All agencies have had to work on the assumption that the injuries which occurred during the weekend of Friday 23 June to Sunday 25 June 2006 were non-accidental. To date no perpetrator has been identified.

Assurance has been received from Homefirst Trust and Barnardo's that no member of staff who was on duty that weekend has been allowed to have unsupervised access to any vulnerable child or adult.

It is extremely difficult for all staff, agencies, and families to live with a continued uncertainty about the cause of the injuries. More than one parent reported to the Review Panel that they would be very worried if any employee on duty that weekend was allocated to care for their children in the future.

The police investigation

Homefirst Trust held a further meeting attended by Barnardo's and RQIA on Friday 30 June 2006. Following on from the discussion at the strategy meeting on Wednesday 28 June 2006 about a police investigation, the social worker said the parents would most likely opt for a PSNI investigation. Homefirst Trust was to clarify this with Y's parents.

The police investigation formally began on Wednesday 5 July 2006. At the time of writing, the outcome was unknown. A file on the case was sent to the Public Prosecution Service on Wednesday 21 March 2007. The file is still under consideration.

What we found

Given that the bruising to Y's arms and hands was unexplained and regardless of whether or not it was considered to be self-inflicted, the Review Panel took the view that Barnardo's staff should have documented the bruising immediately and reported it to the out-of-hours emergency duty social worker. It should have been a crucial management decision to follow up and investigate the injuries noted by Barnardo's, requiring the injuries to be medically examined and the circumstances to be assessed with no assumptions about how the bruising was caused. This did not happen.

Barnardo's did not seek immediate advice from Homefirst Trust, which would have been expected given the information about the extent of the bruising and in view of Y's age. This would have allowed a decision to be taken about which protection procedures needed to be followed and whether or not staff should have been suspended.

It was notable that three medical personnel examined the young person. There was no specialist forensic examination, but at different times the three doctors raised the possibility that the bruising could have been caused by restraint, was suspicious and not consistent with self-harming behaviour. There was no record of the doctors considering activating safeguarding procedures, or checking whether they had already been activated, which they should have done to comply with Homefirst Trust's procedures to protect vulnerable adults. This raised a concern about the level of awareness by various professional disciplines of policies and procedures for protecting adults in the NHSSB area, and about the implementation of these policies and procedures.

The decision by Barnardo's not to invoke safeguarding procedures was critical. It led to:

- a delay in reporting the matter to Homefirst Trust, which was legally responsible for Y during Y's stay at Cherry Lodge;
- potential risks for the children being looked after in Cherry Lodge;
- delays in seeking medical examinations; and
- repeated medical examinations for Y.

Given the uncertainty surrounding the injuries, Y's evident distress and the lack of clarity about the first reporting of the bruising, Barnardo's – in consultation with the other agencies – should have invoked immediately the appropriate procedures for protecting vulnerable adults. It is always possible to stand down these procedures if injuries are found to be accidental or self-inflicted.

What we recommend as points for action and self-assessment

- The agencies involved in this incident should take steps to ensure their staff have guidance to prevent any delay in investigating any such unexplained injuries in the future.

- All staff, or agencies who have concerns about unexplained injuries or suspicions of abuse in children's services should:

  - document and report these immediately and appropriately in line with the policy and procedures set out in Co-operating to Safeguard Children guidance[9]; and The Regional Child Protection Policy and Procedures[10]
  - contact the out-of-hours social work service for advice, if required, after 5.00 pm or at weekends.

- RQIA should clarify with Trusts the role of RQIA in the investigation of any child or adult protection incidents.

[9] "Co-operating to Safeguard Children" DHSSPS (2003), can be accessed at: http://www.dhsspsni.gov.uk/show_publicationstxtid=14022

[10] Area Child Protection Committees' Regional Policy and Procedures, Northern Ireland, 2005. The ACPC Regional Policy and Procedures can be accessed at: http://www.childrensservicesni.co.uk

- Barnardo's should ensure that all staff are aware and competent in the use of the policies and procedures in place in relation to child and vulnerable adult protection.

- Barnardo's should review its child and vulnerable adult protection training for staff at all levels who are involved in caring for children and young people.

- Homefirst Trust should provide all health and social care staff with regular refresher training in child and adult protection. This training should be essential for all staff, with systems in place to monitor attendance.

- Homefirst Trust should review:

  - the effectiveness of multi-disciplinary training in child and vulnerable adult protection; and
  - access to forensic medical expertise for children and young people with a disability.

- The agencies should ensure that if a young person over 18 years of age accesses respite in a children's facility, everyone involved is clear that the Protection of Vulnerable Adults Procedures will apply.

- Homefirst Trust should review its transition planning for young people to ensure that appropriate respite care provision is available and safeguarding arrangements are in place for young people over the age of 18 years.

- Pending any clear outcome from the police inquiry, Barnardo's and Homefirst Trust should undertake a full assessment of all members of staff who were on duty that weekend to determine their ability to continue to work in a health or care service and determine their need for supervision and training. Such an assessment will have to take into account employees' rights and assurance should be given to the families who have used and hope to use Cherry Lodge in the future.

- The Panel was aware of the fact that many recommendations in this report reflect the issues described in Our Children and Young People - Our Shared Responsibility. All organisations should therefore view the recommendations in this report as being complementary to those detailed in Our Children and Young People - Our Shared Responsibility[11] which was produced by the Social Services Inspectorate in Northern Ireland in December 2006.

[11] Our Children and Young People - Our Shared Responsibility, Inspection of Child Protection Services in Northern Ireland, Social Services Inspectorate, DHSSPS, December 2006

Chapter 3: Review of access to Cherry Lodge and how children's rights were upheld by Homefirst Trust

We reviewed information provided by Homefirst Trust about the nature and type of children and young people admitted to Cherry Lodge. We considered how their rights and best interests were upheld in:

- the process of assessing them before they can be admitted to the unit;
- their care plans; and
- reviews of children and young people placed in the unit.

Firstly, we looked at how the needs of the child were assessed against the criteria for admission to the unit. We also examined how children's views were taken into account when plans were being made with them or for them. The Panel recognised that many of the children have communication difficulties associated with their learning disabilities, but good practice would nevertheless indicate that every attempt should be made to obtain a view from the child. To set this in context we initially looked at the criteria for admission to Cherry Lodge and any input by the child to the process.

In this chapter we consider:

- **What Cherry Lodge did (its purpose and function)**
- **Criteria for admitting children and young people to Cherry Lodge**
- **How the disability resource panel operated**
- **The need for multi-disciplinary assessments**
- **Minutes of disability resource panel meetings**
- **Minutes of a meeting on Tuesday 5 September 2006**
- **Were all children's needs being met?**

Our recommended points for action and self-assessment are at the end of the chapter.

What Cherry Lodge did (its purpose and function)

Cherry Lodge is a three-bed respite home located in Randalstown and offers short term periods of care to children and young people with complex disabilities up to the age of eighteen years. The service started as a Home from Home service which was contracted by Homefirst Trust with Barnardo's (NI) as a family placement respite service and not one where children stayed overnight. The house was opened in 1993 to provide minimal residential support to help the family placement service and, at that time, it was anticipated that the house would only operate for three days a week.

Homefirst Trust changed the contract and withdrew the family placement element, even though this was the main focus of the original service. The growth to a seven day residential service happened gradually in response to demand rather than being a carefully planned and funded service development. At the time of the review,

Cherry Lodge was providing a range of provision for approximately thirty children, including shared care, overnight stays and day care arrangements.

What we found

The Panel did not find evidence to indicate that a review of Cherry Lodge's statement of purpose and function had taken place as a result of the change described above. The statement of purpose is a document which outlines the purpose of a facility and explains what type of service is offered. The production of such a document is a requirement under the Children's Homes Regulations (Northern Ireland) 2005[12]. A copy of the statement of purpose for Cherry Lodge can be read in Appendix 7.

The Panel's view was that, the statement of purpose and function should have been expanded to indicate how the service was developing staff to be able to manage children with a wide range of disabilities, including severe learning disabilities, autism, self-injurious behaviour as well as complex health needs.

Criteria for admitting children and young people to Cherry Lodge

Cherry Lodge's criteria for admitting young people, as specified in its service and budget agreement, were that:

- children and young persons must not be over eighteen years of age;
- children and young persons must have a recognised disability; and
- all children and young persons must be assessed before coming to Cherry Lodge.

What we found

In the eight files examined, there was little evidence to indicate a full multi-disciplinary assessment being carried out before a child or young person was placed in Cherry Lodge. The other criteria were met apart from the one admission for Y who was over 18 years old.

How the disability resource panel operated

Homefirst Trust set up a disability resource panel around April 2005. The purpose of the panel was to allocate children and young people to Homefirst Trust's short-break services and to make decisions about the provision of other appropriate support packages, such as assistance at home or direct payments.

Homefirst Trust guidance on the panel stated that, when caring for any child with complex needs, staff should:

- promote an approach that centres on the children and their families;

[12] The Children's Homes Regulations can be accessed at: http://www.opsi.gov.uk/sr/sr2005/20050176.htm

- be able to show they worked in partnership with the family to decide the child's needs; and
- plan and co-ordinate effective care within the resources available to them.

We reviewed the panel and the criteria it used for allocating places. This was to enable us to find out if placements were in accordance with the home's statement of purpose, the child's needs and the child's compatibility with other children being placed.

What we found

We considered Homefirst Trust's guidance to staff on how to use the disability resource panel. The guidance did not indicate whether or not the panel considered a home's statement of purpose when deciding on the appropriateness of a placement.

A number of different senior social workers chaired each panel meeting. There was no evidence in the audited notes of the meetings of any face-to-face discussions with the social workers presenting cases.

The guidance stated that "the social worker will take the lead role in presentation to panel". In reality, the panel usually received information in the form of a written report. Face-to-face discussion with the social worker involved with a child would have provided added knowledge to help decide if a child suggested for placement is suitable.

The panel's chair did not appear to have a brief to comment on whether a proposed placement for a child was appropriate, given the home's statement of purpose and what was known about other children placed there.

Our scrutiny of the guidance and how the disability resource panel operated suggested that the guidance directed staff to decide if a child was eligible for a service, to check if a place was available, and to inform the family.

There was no written evidence available that the decision to place children was based on:

- any discussion with or consent by the child, or an explanation of why a child might not be able to participate in such a discussion;
- how compatible they were with other children; or
- a review of any integrated, comprehensive assessment of risk and need for each child.

The need for multi-disciplinary assessments

The guidance for staff stated that assessments completed for Homefirst Trust's disability resource panel should be multi-disciplinary. It would therefore be expected that reports, for example, from a community nurse, clinical psychologist, paediatrician or speech and language therapist might be presented alongside the social work report.

What we found

The peer reviewer took a sample of five application forms of cases submitted to the panel and found no evidence of a multi-disciplinary assessment. Nor did the reviewer find any evidence of reports being received, from other professionals, to enable the panel to undertake a multi-disciplinary assessment.

When children with complex needs were considered for respite the panel did not routinely request medical reports. These would have helped the panel to assess the child's needs and any risks in placing them in Cherry Lodge.

None of the eight file records audited by the RQIA specialist advisor or in the peer reviewers' audit of children placed in Cherry Lodge between 1 August 2005 and 1 August 2006 provided any evidence that these children had been presented to the disability resource panel because the panel only dealt with **new** applications and only began in April 2005.

Minutes of disability resource panel meetings

We examined minutes of disability resource panel meetings between 1 August 2005 and August 2006 (seven meetings in total).

What we found

It was not clear from the minutes if the panel reviewed the successes or difficulties of previous placements or the appropriateness of placing children who were presenting a challenge to the service in either Cherry Lodge or the Trust's other respite services. The minutes we reviewed had no evidence of a social worker or other professionals attending to make a presentation of a child's need for respite.

Minutes of a meeting on Tuesday 5 September 2006

One minute that was outside the dates we examined did include a paragraph about one of the young people whose file had been reviewed. It was of a meeting on Tuesday 5 September 2006 and we considered it important because the young person had a severe learning disability, bilateral deafness, challenging behaviour and attention deficit hyperactivity disorder (ADHD).

The minutes stated: "requires assistance with all aspects of personal care" and "can present with serious risk to younger children if not fully supervised...". It was noted that a behaviour nurse was involved in the person's care.

The panel concluded that this young person should receive respite from three services, one of which was Cherry Lodge. The minutes gave no indication of any discussion about whether or not Cherry Lodge – or the other two services – required any form of support to manage the young person's behaviour.

This approach revealed that the panel dealt more with the characteristics of the young person than with managing the risk their behaviour posed, or with the appropriateness of such placements in the unit. We queried this practice in terms of

the Trust's requirement to consider the overall assessment of a child's needs and to consider whether or not the available respite provision can meet those needs or what additional support might be needed.

Were all children's needs being met?

We were unsure how the disability resource panel co-ordinator recorded areas of children's needs that were not being met. The Trust's assistant principal social worker confirmed that unmet needs were recorded by a list attached to the panel's meeting notes. This detailed all children awaiting respite care, including domiciliary support (assistance provided at home) and those who requested direct payments to fund their own care packages.

Minutes of the meeting did not indicate any discussion on what further action was to be taken to address the unmet needs or to have them considered in another forum. In 2005-2006 Homefirst Trust indicated an average of thirty children registered as receiving respite at Cherry Lodge. The unit admitted children aged 6 to 18 years for respite and had a waiting list of ten children. Length of stay varied between a few hours for day respite and one-four consecutive evening stays.

A new assessment tool, Understanding the Needs of Children in Northern Ireland[13] (UNOCINI) is considered an example of good practice in assessing children's needs. It clearly states strengths, needs and risks and, in most circumstances requires the consent of the young person, their carer or both of them. Any professional can complete it and there is an expectation that it will be multidisciplinary. From September 2006 Homefirst Trust staff were using UNOCINI to make submissions to the panel.

What we found

The disability resource panel would appear to have been the most appropriate forum:

- to review demand for places by children with differing complex health care needs seeking access to respite services; and
- to make informed decisions about the suitability of their being placed in Cherry Lodge.

The panel could have functioned better if Homefirst Trust had agreed clear criteria to select access to a respite or other care service. It would also have been improved by a more effective method of recording and taking actions about needs that are not being met.

Such a structured process would have helped Homefirst Trust to gather and collate information about unmet need. It would have better described the services needed, instead of just the number of children waiting to receive a service. The Trust and NHSSB could have used this information to better plan their children's services and

[13] UNOCINI - Understanding the Needs of Children in Northern Ireland, Pilot Multi-Agency Assessment Framework, DHSSPS, 2006

commissioning priorities, given the indication of increased need in Northern Ireland that Appendix 8 of this report outlines.

What we recommend as points for action and self-assessment

- Homefirst Trust should review its practice guidance for how the disability resource panel operates. This should include:

  - Clearly setting out for staff what the panel is for and the criteria that the panel will use to agree access to respite services.
  - Clarifying the membership of the panel and the role of the chair.
  - Ensuring that social workers seek information from all disciplines and agencies involved with children and their families to provide an up-to-date, comprehensive assessment of a child's needs and any risks to their care.
  - Promoting teamwork across disciplines and integrated assessment procedures.
  - Providing an opportunity for children and carers to comment on how the services that they received were delivered and to contribute to the assessment.
  - Reviewing the benefits and disadvantages of rotating the post of chair of its disability resource panel.

- Homefirst Trust's disability resource panel should consider the age, needs, and risk behaviour of each child. This will help to ensure:

  - the panel chooses the most effective placement option in terms of how compatible a child is; and
  - that children are placed in an environment that adequately and safely meets their needs.

- All professionals seeking access to respite beds should fill in UNOCINI forms before submitting assessments to resource allocation panels to improve decisions about providing access to services.

- Homefirst Trust should ensure that future admissions to respite care services are considered only within the agreed age limits for the service and an accurate updated statement of purpose for the home. (Appendix 7 sets out the home's statement of purpose).

- Homefirst Trust should review its processes for planning its services and how its records unmet need. This would promote a fair pattern of providing or commissioning services that is based on assessed need and takes account of availability of placements, funding and local priorities.

Chapter 4: Review of Homefirst Trust's assessment and care planning; and of placements of children and young people in Cherry Lodge

In this chapter we review:

- **What systems were in place to assess, plan and review care?**
- **Was care planning and review carried out in an integrated way?**
- **How were healthcare needs monitored of children and young people placed in Cherry Lodge?**
- **How well did Homefirst Trust and Barnardo's comply with Looked After Children (LAC) regulations?**
- **Visits by social workers to the Cherry Lodge children and young people**

Our recommended points for action and self-assessment are at the end of the chapter.

What systems were in place to assess, plan and review care?

Records indicated that six of the eight children whose files were audited attended Cherry Lodge for overnight stays. The other children attended for day care only. The children and young people admitted for respite to Cherry Lodge were very vulnerable and had complex needs. We therefore thought it was vital to audit how they were assessed and the procedures for planning and reviewing their care – and do this against the quality standards of safe and effective care, corporate leadership and accountability and the Children (NI) Order 1995 Regulations and Guidance Volume 4 - Residential Care.[14] Under Article 25 of the Children (Northern Ireland) Order 1995, a child is "looked after" by a Trust if the child is in the Trust's care *(i.e. under a Court Order)* or is provided with accommodation for a continuous period of more than 24 hours by the Trust. Cherry Lodge is a registered children's home which provides residential respite care. Children who receive this service, whilst not in the care of the Trust are, nevertheless, provided with accommodation in the home by the Trust. They therefore come within the full regulatory provisions of the Children Order insofar as these relate to "looked after" children in a residential setting.

We therefore would have expected Homefirst Trust to have had reliable and effective systems in place to ensure the Trust met its legal requirements. We would also have expected it to have effective systems in place to discharge, monitor and report on its responsibilities for meeting its legal duties and working with other agencies.

We would have expected Homefirst Trust to systematically assess risks in all areas of its work and have supervision systems in place that met professional codes of practice and regulatory requirements.

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[14] The Children (Northern Ireland) Order 1995
The Children Order Regulations and Guidance consists of the following:
Volume 1: Court Orders and other Legal Issues
Volume 2: Family support, Childminding and Day Care
Volume 3: Family Placements and Private Fostering
Volume 4: Residential Care
Volume 5: Children with a Disability

Our social work peer reviewer audited the same eight fieldwork files relating to children with complex needs that were audited by the RQIA specialist adviser, who also examined Barnardo's residential files. The peer reviewer examined how fieldwork and residential staff worked together and contrasted the findings with what the residential files revealed.

The findings were consistent in both the fieldwork and residential files. There was evidence that some sections of Looked After Children (LAC) pre-admission plans were not completed and this has been documented on the evidence grid used by the Review Panel. This grid is available on request from RQIA.

What we found

The audit provided evidence that in only two of the eight cases there were:

- assessments carried out on children before they were admitted to Cherry Lodge; and
- decisions made as a result of a full discussion about specific children's needs.

The rest were not in line with statutory requirements. This specifically related to the assessment of children's needs as outlined in The Children (Northern Ireland) Order 1995.[15] Staff relied heavily on the spoken word and getting information from conversations with the children's parents. Although these are legitimate sources of information, problems arise if this information is not verified, recorded and shared to inform care planning and care responses. This can create a particular risk in a service where numerous relief staff are on duty.

Where assessments were available they had not always been reviewed or updated since the initial assessment. For example, one young person was referred for assessment on 18 December 2002 but the actual date of assessment was 3 September 2003.

The assessments provided no evidence that risk had been thoroughly assessed, or of the impact of admissions on other children and young people who also had complex needs. This was despite records relating to challenging behaviour of many children placed in Cherry Lodge.

Was care planning and review carried out in an integrated way?

A care plan based on a comprehensive assessment of need is the cornerstone to providing good quality, safe and effective care, particularly for vulnerable children and young people. It should make it absolutely clear to everyone what they should expect from the service. The people who commission and provide care services, and the children and families who use them, should know what is planned and what

[15] The Children (Northern Ireland) Order 1995 can be accessed at:
http:/www.opsi.gov.uk/si/si1995/Uksi_19950755_en1.htm#tcon
The Explanatory Note can be accessed at:
http://www.opsi.gov.uk/si/si1995/Uksi_19950755_en_55.htm#exnote

should be delivered. Without a care plan there can be confusion and unplanned responses to the child's needs.

Looked After Children (LAC) forms have been developed and designed to facilitate effective care planning and review processes. The Department of Health and Social Services and Public Safety (DHSSPS) strongly advise all Trusts to use these forms to ensure care planning and review is carried out in an integrated way. These forms contain sections for inclusion of essential information which should have been completed on any child placed for respite in Cherry Lodge. The Panel noted evidence that sections of LAC pre-admission plans were not completed.

The Children (Northern Ireland) Order 1995 and the accompanying regulations which relate to care planning and review require a written care plan for each Looked After Child. These also set out what each care plan should contain, the information to be reviewed and the expected frequency of review. (See Appendix 9).

Evidence provided showed gaps in seven of the eight fieldwork files audited in the care planning process by Homefirst Trust. The care plans on file consisted of a list of points and issues, which were documented at the end of the child's review, as opposed to a plan of work with specific objectives. Although parents attended reviews, there was little evidence to show that they, or where possible the child, endorsed the plan.

One care plan had been incomplete for four years. There was no evidence that Homefirst Trust's quality assurance system monitored or audited fieldwork files. Barnardo's did not comment on the absence of thorough, updated care plans, although – as part of their monthly monitoring process – they had also audited four of the eight files that we audited.

There was limited written evidence, from the LAC documentation, that the care provided to the children was systematically assessed, planned, and altered according to the children's changing needs, behaviour and medical conditions.

How were healthcare needs monitored of children and young people placed in Cherry Lodge?

Disabled children in respite care have an added level of dependency.

Article 23 of the UN Convention on the Rights of the Child (UNCRC[16]) states that children with a physical or mental disability have the right to healthcare services that help them to integrate socially as far as possible, and to develop as individuals. This is the standard by which services and those who provide them must be measured.

It is essential that social services and respite units share information about children's healthcare needs so that respite placements are appropriate and safeguard children's care because of the complexity of their healthcare conditions and needs.

[16] The UNCRC can be accessed at: http://www.ohchr.org/english/law/crc.htm

The paediatric peer reviewer audited the same eight Homefirst Trust fieldwork case files as the social work peer reviewer and took a sample of four Cherry Lodge residential files to find out if the information the files held about the child's healthcare needs was adequate in helping to decide the placement and look after their healthcare in the placement.

The peer reviewer examined these important issues:

- Diagnosis and complexity of healthcare needs.
- Medical input to files through reports and attending LAC reviews.
- Specialist nurse input to files through reports and attending LAC reviews.
- Presence or absence of detailed healthcare plans, including risk assessment and intimate care procedures and protocols where appropriate.

Each of the eight children had complex needs. This is particularly challenging when providing appropriate, timely, child-centred care in a community setting. Such children require a range of specialist services beyond the type and amount required by children generally or by children with single disabilities and long-term illnesses.

What we found

The medical care and nursing care reports contained in the Homefirst Trust medical and nursing files in the eight cases audited were of a high standard. Homefirst Trust used the Leeds Nursing Dependency Score, a scale that establishes the probability that a child or young person has complex physical health needs and details how best to respond.

However, the Homefirst Trust social work fieldwork records had no evidence of this medical and nursing information and the file also had no sections earmarked for recording healthcare issues or filing medical and nursing reports.

Comprehensive medical and nursing advice and reports were **not** sought or provided as a matter of course to assist with assessment and care planning. There was no evidence of them in the Barnardo's residential file and the audit of these files suggested they were not accessible to residential staff working with the children with complex needs.

We also found that attendance at LAC reviews was a major issue. There was no evidence to show that medical input was always requested at LAC reviews. Even when it was clearly requested, paediatricians or psychiatrists did not always attend these reviews.

This indicated the possibility of a more general problem with people's capacity to take part in these procedures and suggested a need to consider reviewing the job descriptions of paediatricians to ensure they reflect the Looked After Children workloads in the Trusts.

The Review Panel considered that the same issues may have applied also to community children's nurses, who carry large caseloads yet who carry out extensive and thorough risk assessments. Sharing all this information with the relevant social

services teams is essential to comply with Article 23 of the UNCRC best practice and the DHSSPS quality standard of effective information and communication. Sharing

information in this way should be a hallmark of health and social care services working successfully together.

How well did Homefirst Trust and Barnardo's comply with Looked After Children (LAC) regulations?

The Children (Northern Ireland) Order 1995, Articles 26, 27 and 92 stipulate the general welfare duties that Homefirst Trust and Barnardo's must meet in planning and reviewing care.

We used a grid to identify how Homefirst Trust met its duties under the Children (Northern Ireland) Order 1995. This grid is referred to earlier and is available from RQIA on request.

What we found

The Panel found that Homefirst Trust fell short of expected practice for LAC reviews.

The six children receiving overnight respite should have had reviews under LAC processes. The audit of both the fieldwork and residential case files in the six children's cases revealed that only one review took place within the statutory timelines.

Apart from one meeting, the reviews were not chaired by the appropriate designated person, the assistant principal social worker. One review was chaired by a grade below a senior social worker. A paper record of the review was available on all of the fieldwork files inspected, but this was not always reflected in Barnardo's residential files.

The agenda and areas discussed in all review meetings did not follow the guidance set out in the Review of Children's Cases Regulations (Northern Ireland) 1996[17] and the associated Children Order Regulations and Guidance Volume 4. Some sections of the LAC report had no commentary, decisions from previous review meetings were not followed through on subsequent review records and the quality of recording on LAC review records was consistently poor. The reviewing officer from Homefirst Trust had not countersigned any review report to indicate his or her responsibilities for monitoring and quality assurance.

Untoward incident reports would be expected to form part of a review and should be noted in the review record. The files reviewed had no evidence of reports of such incidents. It was not clear where copies of any untoward incidents were filed. No clarity about this was provided to the Panel by the Trust.

[17] The Review of Children's Cases Regulations (Northern Ireland) 1996 can be accessed at: http://www.opsi.gov.uk/sr/sr1996/Nisr_19960461_en_1.htm

Under the DHSSPS quality standard of providing safe and effective care, Homefirst Trust would have been expected to promote an approach that centres on people and actively involves children and carers in developing, implementing and reviewing care plans and in monitoring a young person's development and changing needs.

Audits of both residential and fieldwork files showed no evidence that children were involved, or that consideration was given to making arrangements for children who were able to, to express their views on matters affecting them.

Article 12 of the UNCRC requires children's views to be listened to by adults when key decisions are being made about their care. This is a standard against which this service is provided. If children and young people are not capable of making their independent views known, the service should ensure they have access to adequately trained and competent advocates.

None of the audited files had evidence of a written contribution from parents or children.

We were concerned about the absence of any processes to systematically hear the views of those who used the service.

Visits by social workers to the Cherry Lodge children and young people

What we found

The visits by social workers to the children were variable. Homefirst Trust told the Review Panel that the Trust applied the Foster Placement (Children) Regulations (NI) 1996[18] which require visits at least every six months unless requested more often by children or their parents. The peer reviewer had expected to find visits on a monthly basis which is generally considered to be good practice, although not a strict statutory requirement, for children receiving residential care. The Review Panel, through RQIA, sought clarity from the Department of Health and Social Services and Public Safety (DHSSPS) on the visiting requirements for children with disabilities in respite care. The Panel found that the guidance on the frequency of visits to children in respite care is unclear.

We found it difficult to catalogue statutory visits, as these were inconsistently recorded on the LAC review record and were not often cross-referenced on contact sheets. We were concerned by the perceived irregularity of contact with these young people. The Panel took the view that despite the lack of clarity on statutory visiting, the nature and complexity of the needs of these children and their families would indicate the importance of regular contact and review. It is important to monitor these children's overall welfare when placed away from home, even for respite.

Nevertheless, despite the irregular visits and the absence of formal recording, the parents we met expressed universal satisfaction with their children's social worker. A

[18] The Foster Placement (Children) Regulations (NI) 1996 can be accessed at: http://www.opsi.gov.uk/sr/sr1996/Nisr_19960467_en_1.htm

number of parents were pleased that their child had had the consistency of the same social worker for several years.

What we recommend as points for action and self-assessment

- Homefirst Trust should ensure that assessing children and young people includes an assessment of risk. The Trust, with Barnardo's, should put in place a strategy for managing risks to individual children and to everyone else in any respite care service.

- Homefirst Trust should provide Barnardo's with medical or nursing reports, and all other information relevant to the care of disabled children placed for respite care to ensure residential staff can care appropriately for children.

- Homefirst Trust should document care plans to comply with its legal and regulatory requirements as set out in the Children (Northern Ireland) Order 1995 and the DHSSPS quality standard of safe and effective care.

- Homefirst Trust should review their arrangements for monitoring social workers' visits to children with disabilities to ensure a high standard of planning and effectiveness, in line with their governance responsibilities, legislative requirements and Article 12 of the United Nations Convention.

- Homefirst Trust and the Northern Health and Social Services Board should review how children and their carers are involved in the LAC review process, given the expectations of the United Nations Convention and of their duty of care to children who are accommodated and looked after.

- Homefirst Trust should audit how social work staff practices comply with legal requirements for LAC and the Northern Ireland Social Care Council Codes of Practice[19], and where required, develop an action plan for improvement.

- Homefirst Trust should audit how visits are recorded and use this to influence how the respite care that has been commissioned is delivered.

- Homefirst Trust should review the effectiveness of its filing systems for Looked After Children and involve the various professionals in agreeing the most effective system to file and share written information.

- Homefirst Trust and other Trusts in Northern Ireland should review workforce planning arrangements for paediatricians and that of other professionals, if appropriate, to ensure that present LAC workloads are reflected.

- The Department of Health, Social Services and Public Safety (DHSSPS) should clarify guidance for social work staff about visiting arrangements for disabled children receiving respite care.

[19] Codes of Practice for Social Care Workers and Employers of Social Care Workers, Northern Ireland Social Care Council, September 2002

Chapter 5: The quality of care and safeguarding that Barnardo's provided at Cherry Lodge

This chapter sets out:

- **How we assessed quality of care and safeguarding**
- **How were medicines managed?**
- **How were incidents recorded and reported?**
- **How was children's behaviour managed?**
- **How were child protection issues handled?**
- **How was risk assessed and managed?**
- **What were staffing levels in Cherry Lodge?**
- **How were staff supervised?**
- **How was Cherry Lodge monitored?**
- **What we found about how staff were trained in safeguarding**
- **How were staff relationships at Cherry Lodge?**

Our recommended points for action and self-assessment are listed at the end of the chapter.

How we assessed quality of care and safeguarding

In March 2006, new quality standards were produced for all organisations providing health and social care. These standards indicate how good governance and best practice should be measured. In reviewing the quality of care and safeguarding we referred to the Quality Standard, theme 2, of safe and effective care[20].

This report indicates that care plans documented by Homefirst Trust were of poor quality. So there was a parallel impact, in that we identified similar deficits in the Cherry Lodge files.

We analysed the information from the audits that the four RQIA inspectors had completed on the files of children admitted to Cherry Lodge. We gave particular attention to how Cherry Lodge managed and administered medicines, and how the unit managed incidents. We also scrutinised information about how the unit:

- managed children's behaviour;
- recognised and reported child protection concerns; and
- assessed and managed risks.

We scrutinised staffing in Cherry Lodge, including team meetings and the supervision of staff.

We also scrutinised copies of monthly monitoring reports, Barnardo's contract with Homefirst Trust, and staff training. We then focused in particular on the serious staff relationship problems in this service as highlighted by Barnardo's in a report submitted to the Review Panel.

[20] The Quality Standards for Health and Social Care - Supporting Good Governance and Best Practice in the HPSS, DHSSPS, March 2006

How were medicines managed?

The RQIA pharmacy specialist advisor audited the same eight files to view how medicines were managed and administered, using the draft care standards which can be seen in Appendix 10.

What we found

A written policy and procedure was in place for managing medicines. However, the inspector's audit highlighted examples of poor practice in three different cases. These included:

- On one occasion a staff member prepared a medicine but someone else administered it.
- In another case parental advice was followed after an incident involving medication, but staff did not contact the hospital.
- In another case an incorrect dose of a prescribed medicine was administered but no-one analysed why this had happened.

All these incidents were contrary to the home's documented policy on managing medicine and therefore carry risks to the children's well-being.

It was unclear whether it was the GP of each child or the Cherry Lodge GP who was in charge of each child's medicine.

Parents were responsible for informing staff in writing of any changes in children's medication. If staff had concerns, they arranged for the manager to contact the child's GP or appropriate healthcare professional, usually the consultant. There is a risk in this practice as staff are not health professionals and cannot assess how appropriate a dosage regime is.

Information on medication changes was not updated. Barnardo's did not use any standard form, which the GP or parent could sign, to notify changes to the dosage of medication.

The central prescription records did not contain specific enough information about how medicines were to be administered to children, including details about the timelines of medicines administered to children as they were required, and medicines administered on specific days.

The names and dosages of medicines were not always spelt correctly on the central prescription records, creating a risk of mistakes.

There was no evidence that prescription records were signed by anyone. Two members of staff should always complete and sign the prescription records.

On one occasion parents forgot to bring in oxygen. There was no written protocol telling staff what to do in these circumstances.

One child, despite a diagnosis of epilepsy, had no epilepsy management plan recorded on file.

During the pharmacy inspection it was evident that staff disguised medicines in food when asked to by parents. It is important that any practice of covert medication should follow very tight guidelines such as those recently published by the Mental Welfare Commission in Scotland [21] and the Nursing and Midwifery Council[22], which is the regulatory body in the UK for nurses.

There was no evidence in any of the eight cases audited of anyone monitoring the systems for recording and administering medicines.

Homefirst Trust provided staff training for dealing with children with specific health needs on courses that lasted one day. Chapter 7 details this. Unqualified staff in the home had to deal with complex issues; for example, administering diazepam through the rectum and feeding through a tube. The Panel considered it unrealistic to cover training in these health issues in such a short period. RQIA raised this matter with Barnardo's and Homefirst Trust following their last inspection in December 2006.

How were incidents recorded and reported?

An RQIA nurse inspector carefully studied records of untoward incidents. (Appendix 11 details the standards the inspector used). This revealed numerous concerns about practices.

What we found

Serious incidents were not properly recorded, responded to or followed up in line with Barnardo's care and control policy. It was therefore impossible to judge if staff responses and actions were well managed and appropriate to the different children's needs. The response was usually reactive rather than based on experience and established practice.

There was no evidence of a technique for writing clear, concise reports. Abbreviations were frequently used, which can lead to ambiguity. We found no evidence of an official report form for incident reports. These were all written on plain notepaper.

We found no evidence of an effective system for giving feedback to staff about the quality of their written reports. No page numbers were evident on some reports and it was difficult to find out if completed reports had been sent on to senior management.

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[21] Guidelines on Practice of Using Covert Medication, Mental Welfare Commission for Scotland, November 2006

[22] NMC Position statement on the covert administration of medicines, Nursing and Midwifery Council, July 2006

We found no evidence of an effective communication strategy for sharing details of incidents or, indeed, of a clear, concise policy – for all staff to follow – on how to manage incidents.

How was children's behaviour managed?

Staff should plan and explain methods that encourage and help children and young people to develop socially acceptable behaviour. The appropriate management of any form of challenging behaviour is a necessary function of any service that provides services to children and adults with learning disabilities.

A child's feeling of being cared for and his or her capacity to develop self-control is influenced by the care he or she gets and from care practices within the children's home. Control should encourage children to understand the relationship between actions and their consequences in a way that enables them to develop inner control.

Barnardo's submitted to us a behaviour management policy that took account of guidance on using restrictive physical methods in special schools, care and health settings such as respite units. This guidance was issued jointly by the Department of Education in schools and the Department of Health in England. The policy used terminology that does not apply in Northern Ireland, such as "local Authority" which could make it difficult for staff to understand. It included written agreement plans, a comprehensive plan for managing behaviour, and written parental consent. The DHSSPS issued Guidance on Restraint and Seclusion in Health and Personal Social Services[23] in August 2005 which should be used to assist in the development of any policy for managing challenging behaviour.

In considering appropriate guidance on the management of challenging behaviour, the Panel recognised that the interpretation of the Children Order[24] requirements may make it difficult for organisations to develop appropriate policies which deal with restrictive practices and physical intervention. The Children Order refers to restrictions of liberty and exclusion as being unacceptable. Application of some restrictive practices, for example locking a kitchen door to prevent access to dangerous cutlery, may, however, be a necessary part of managing challenging behaviour in children with disabilities. Staff correctly believe that such a practice may be necessary to keep a child safe and don't always consider that there is also a restrictive element to their actions. Such practices must only be used in the context of appropriate policies, procedures, training and monitoring systems.

The Panel took the view that it would be helpful if the new care standards currently being developed by the DHSSPS took account of the needs of children with

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[23] Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005. It can be accessed at: http://www.dhsspsni.gov.uk/restraint_and_seclusion_august_2005-2.pdf]

[24] The Children (Northern Ireland) Order 1995 can be accessed at:
http:/www.opsi.gov.uk/si/si1995/Uksi_19950755_en1.htm#tcon
The Explanatory Note can be accessed at:
http://www.opsi.gov.uk/si/si1995/Uksi_19950755_en_55.htm#exnote

disabilities and ensured that standards were developed which assisted organisations to meet these needs but do not conflict with the spirit of the Children Order.

What we found

None of the eight audited files had a clear behaviour management plan in place, although the files indicated that each of these children was exhibiting some degree of challenging behaviour. There was no evidence that Homefirst Trust or Barnardo's had queried, monitored or reviewed how behaviour was managed.

We found recorded evidence in one case of a member of Cherry Lodge staff being given direction and advice on how to manage a child's behaviour from both Barnardo's staff and the psychologist from Homefirst Trust.

We were concerned about evidence from the number of incidents we reviewed that volatile and unacceptable behaviour was being tolerated for several children. The behaviour would have warranted reviewing a child's care plan and agreeing a strategy for managing the child's behaviour. These actions would have helped staff manage difficult behaviour.

We learned that the philosophy behind Cherry Lodge was that "it should be able to take on and perform the tasks and procedures, as well as the behaviours, that parents were expected to deal with".

This needs to be set in the context of the unit's statement of purpose. The philosophy and the service Barnardo's set out to deliver meant that the service had an even greater responsibility to ensure that the staff it employed had all the training, management, supervision and help to cope with the demands these children would inevitably put on frontline carers who were not the children's parents.

There was limited evidence that the necessary training required by staff to manage challenging behaviour was available to Barnardo's staff. This may be as a result of Barnardo's (NI) as the provider of the service responding to the various expectations of parents, the NHSSB and Homefirst Trust at the expense of what could be safely delivered.

In records submitted to us by a senior Barnardo's manager, frustration was expressed at being unable to get the right help and guidance from specialist staff in Homefirst Trust. It was not clearly recorded who was accountable or responsible for providing this guidance to the frontline staff.

Evidence from the review of incident records and supervision notes suggested that when members of staff at Cherry Lodge were struggling to manage the behaviour of particular young people, they did not receive specialist support, for example, early advice from a psychologist or the guidance they requested from Homefirst Trust.

In establishing community support for children with learning disabilities and challenging behaviour, good practice would indicate that the behaviour support provided for a child and family in their own home should extend to that child and to the staff in a respite setting.

People and organisations that provide services should work in partnership to achieve a common approach to developing policies, procedures and training for managing challenging behaviour. This will ensure a consistent approach for families.

How were child protection issues handled?

In April 2005 Northern Ireland's four area Child Protection Committees issued a new child protection policy and procedures[25] to all agencies. These emphasised that disabled children had the same right as all other children to protection from harm.

Disabled children may have additional needs. For example they may require intimate care or have communication difficulties. The result may be that they are unable to recognise abusive behaviour or convey their experiences to others. For example, they may find it difficult to tell the difference between appropriate and inappropriate touching. Therefore parents, carers, the community, voluntary and statutory agencies must all be vigilant, to prevent child abuse and neglect.

A discussion paper published in January 2007 by HM Treasury, Department of Education and Skills[26] confirms this and emphasises the importance of recognising the particular vulnerabilities of this group of children. The paper quotes from a US study which explained that, "disabled children are more likely to suffer from abuse, as they might be dependent on others for care and sometimes do not understand or cannot communicate that they are being abused".

Safeguards for children with a disability should be the same as those for other children and staff need to be aware of the additional vulnerabilities of this group of children as described above. As in all child protection cases, this must involve people from all relevant disciplines. They need to agree who is responsible for investigating any child protection issues.

What we found

Earlier in this report we noted that Barnardo's had a written policy and procedure in place at Cherry Lodge for protecting children. Nevertheless the file audit indicated that residential staff failed to recognise and report – in line with the procedures – on the injuries noted to Y in June 2006.

This happened on several other occasions. For example, one risk assessment identified that the young person exhibited inappropriate sexualised behaviour and that other young people might be at risk. Yet there was no further reference to this information in the young person's file, or of how the unit managed the risk.

The review of children's files showed that a small number of children, during their time in respite care, were the subject of incidents that fell within the category of child protection. In some of these incidents:

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[25] Area Child Protection Committees' Regional Policy and Procedures, Northern Ireland, 2005. The ACPC Regional Policy and Procedures can be accessed at: http://www.childrensservicesni.co.uk

[26] Policy Review of Children and Young People Discussion Paper, HM Treasury, Department of Education and Skills, 2007

- injuries to a child or young person were not reported to parents or professionals;
- information that had implications for caring and protecting specific children was not shared with the community team in line with Barnardo's child protection policies and procedures;
- details of incidents were inadequately recorded; and
- it was unclear which of the agencies involved with the unit was accountable for or should take the lead in protecting children.

RQIA has followed up all concerns in specific cases with Barnardo's and Homefirst Trust, so that these can be investigated further.

How was risk assessed and managed?

Assessing risk and managing it effectively and thoroughly is central to ensuring the safety and welfare of individuals and residential groups. But this can only succeed if managers understand and know the main risks of young people in residential care.

They can then prioritise risks, take action and follow this through with thorough monitoring. When they assess risk, managers must consider what impact specific types of behaviour have on an individual, the resident group and carers.

What we found

The audit of the eight residential files revealed that Barnardo's, in seven of the eight cases, had signed and dated risk assessments, but had not updated them. This was despite major changes noted in children's care plans, their behaviour and in the medical conditions.

Of the eight files audited one file had no risk assessment at all. In the remaining seven, the risk assessments were out of date. Three assessments had not been updated since 2003 or earlier. The remaining four had not been updated in 2005.

There was a lack of co-ordination in analysing and managing risk by Barnardo's, Homefirst Trust and professional staff allied to the Trust. This was reflected in the absence of composite and comprehensive risk assessment covering all the professional disciplines involved in all files audited.

Although systems and structures were in place for monitoring how risk was managed, evidence from the cases we reviewed did not show that Cherry Lodge management, Barnardo's senior management, Homefirst Trust or the NHSSB were taking actions to assure the quality of these systems and structures.

What were the staffing levels in Cherry Lodge?

Evidence shows that staffing for Cherry Lodge from June 2005 was as follows:

- A children's services manager (Certificate of Qualification in Social Work – CQSW) with overall responsibility for managing the residential unit and who also spent some time in a special support service.

- Team leader (UK Nursing and Midwifery Council (NMC) registered nurse) with delegated responsibilities for the residential unit, including staff supervision.
- Residential project workers: two full-time (37 hours); three part-time (30 hours); one part-time (20 hours); one part-time (12.5 hours); six relief staff.
- Two staff who are on duty at night.
- Cook.
- Domestic staff member.
- Administrator.

Barnardo's told us that a minimum of three staff were always on duty during the day, which was in line with staffing requirements for this unit. In some cases this was increased to meet children's needs.

Effective team meetings are crucial to maximise the continuity of care, management and of staffing. They enable staff to plan and take part in activities appropriate to caring for and developing children and young people.

Staff should have the opportunity to propose agenda items. Agendas should be prepared far enough in advance of meetings for staff to prepare items and contribute to discussions.

What we found

Eleven team meetings were held between 1 August 2005 and 1 August 2006. We reviewed their minutes. We found it hard to identify who chaired meetings, took minutes or how agendas were prepared. Areas identified as requiring action in one meeting were not reported on in the subsequent meeting. This was a consistent theme of the minutes.

Actions to be taken frequently related to all staff but no timescales were set for completing them. We considered it to be significant that issues that required discussion, and that were important to the functioning of the home, were not reviewed; for example, managing children's behaviour and responding to child protection concerns.

The Barnardo's annual monitoring report 2005/2006 reported that team meetings were held monthly. The report continued:

> "Turnover of contracted staff is limited, a high proportion of staff have been in post since the unit opened more than ten years ago: the turnover of relief staff tends to be greater and these are replaced as necessary through the usual means of recruitment.
>
> Sickness levels within the unit are low for the type of work being undertaken. Regular training and where necessary, training up-dates or refreshers are provided to the whole of the staff team."

Staffing information levels during the weekend of the incident show that, of the staff on duty, three were permanent employees who had worked in the unit for a number of years. two of whom had recognised qualifications. Two of these staff, however,

were working on night duty. The remainder of the staff on duty that weekend were relief workers who worked as and when required, many of whom did not have a recognised qualification. All care staff in residential child care were among the priority groups for registration with the Northern Ireland Social Care Council from 1 June 2005, if not already registered with another recognised regulatory body. No evidence was provided that Barnardo's had arranged for the process of registration of their staff at Cherry Lodge.

How were staff supervised?

The Children Order Regulations and Guidance Volume 4 - Residential Care[27], chapter 2, 2.15 states:

> "All staff should receive supervision from their line manager. Supervision should be on a one-to-one basis, in private and so far as is practicable, free from interruption." It continues: "Residential social workers should ideally receive supervision for one to one-and-a-half hours at least once every four weeks."

What we found

The evidence made available to us suggested a lack of direction and support to staff through regular and good quality supervision. Barnardo's did have a supervision policy but the Review Panel found evidence that there was a lack of clarity about how it should be applied. An example of this was that a senior Barnardo's manager in the annual monitoring report of 2005/2006 dated 18 July 2006 stated:

> "Supervision is provided to staff by the children's services manager and by the team leader on a monthly basis and appraisals are held annually. The unit manager (CSM) is provided with monthly supervision by the responsible assistant director and is also subject to quarterly performance review system and annual appraisal."

This was different from a statement made by the director of Barnardo's who stated that:

> "In Barnardo's, assistant directors of children's services are managed through quarterly performance reviews. This is also the situation for children's services managers."

Such inconsistencies indicated to the Panel that the supervision policy was not universally understood.

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[27] The Children (Northern Ireland) Order 1995
The Children Order Regulations and Guidance consists of the following:
Volume 1: Court Orders and other Legal Issues
Volume 2: Family support, Childminding and Day Care
Volume 3: Family Placements and Private Fostering
Volume 4: Residential Care
Volume 5: Children with a Disability

The requirement within Barnardo's was that all assistant directors of children's services received quarterly performance review and that children's service managers also received quarterly performance review. New children's service managers received monthly management review as did new assistant directors. Thereafter, Barnardo's reported to the Panel that it was a matter of individual arrangements depending on the needs and circumstances of line management. The line management requirement was for quarterly performance reviews.

The training and development needs of staff did not appear to be adequately addressed by any training and development framework from Barnardo's. There was no evidence available to us that any **residential** staff appraisals had taken place during the period we reviewed. There was an overall lack of recorded and reflective decision-making in response to issues identified by the frontline project workers.

Although the Review Panel did not request detailed written records of supervision, Barnardo's (NI) made available a small number of supervision records files, which were sampled.

In reviewing the supervision records we noted that there was:

- no pre-set agenda;
- a lack of accountability in the social care task; and
- no direction provided on important issues raised during supervision meetings.

A management decision was taken in February or March 2006 by a senior manager in Barnardo's that annual appraisals for staff in Cherry Lodge which were due to be completed in April 2006 should not be undertaken at that time. This was based on an assessment of some particular staffing difficulties in the unit.

A senior Barnardo's manager completed a quarterly review report, a health and safety report and a quarterly performance review report. We saw no evidence to indicate that the difficulties these reports identified were addressed by an agreed action plan approved by management at a more senior level. For the period we reviewed we only received evidence of one record of appraisal, dated 5 May 2005, of senior staff.

From the evidence available to us, there was a lack of direction, advice, guidance and follow-up action for staff through regular and good quality supervision, hand-over meetings, and staff team meetings.

How was Cherry Lodge monitored?

The Children's Homes Regulations (Northern Ireland) 2005, Regulation 32 (1)-(5)[28] sets out the legal framework for the monitoring of children's homes. It states that if the registered provider of a children's home is an individual, but is not in day-to-day charge, he or she must carry out a monitoring visit at least once a month. He or she

[28] The Children's Homes Regulations can be accessed at: http://www.opsi.gov.uk/sr/sr2005/20050176.htm

must inspect specific records to form an opinion about the standard of care the home provides. Barnardo's had developed a standard form to report on this regulation.

What we found

A Barnardo's manager routinely completed monthly monitoring reports and submitted these to the Director of Barnardo's, Homefirst Trust and RQIA. So the systems were in place to highlight any deficiencies in this service.

However, we were struck by the number of deficiencies we identified in the file audits in Cherry Lodge that indicated a lack of scrutiny of recording systems. What is difficult to understand is why this was not picked up by the regular routine monthly monitoring reports completed by the responsible senior Barnardo's manager as these would have been scrutinised and signed off by the director of Barnardo's (NI). Shortly after we began our review, information about serious staffing difficulties brought into question the many assurances given in monthly monitoring reports.

Barnardo's routinely completed monthly monitoring reports did not contain much commentary about the practice of staff or the effectiveness of systems put in place by Barnardo's to identify shortcomings or gaps – or actions suggested to address these. This would have been expected in terms of best practice by any monitoring officer. Shortly after we began our review the information about serious staffing difficulties brought into question the many assurances given by the monthly monitoring reports.

An RQIA inspection report, September 2005, before the incident recommended that:

> "Barnardo's should conduct some form of user survey from time to time. This should include for example, parents' views about access to respite care, their anticipated need for services after 18 years, their experience of reviews and the extent to which Barnardo's staff have skills in communicating with their children"

There was no evidence this was followed up in subsequent monitoring reports yet this is fundamental to a child's right to have their views listened to and properly considered as expressed in Article 12 of the UN Convention on the Rights of the Child[29]. It had not been actioned by Barnardo's and was repeated in a subsequent RQIA inspection report in December 2006.

What we found about how staff were trained in safeguarding

We received documented evidence that the children's services manager had provided training in safeguarding children and young people to nine frontline staff in May 2005.

A Barnardo's assistant director provided further safeguarding training to the children's service manager, team leader and four other staff in October 2005. The circumstances surrounding the June 2006 incident indicate that staff were unable to implement the learning they should have gained from this child protection training.

[29] The UNCRC can be accessed at: http://www.ohchr.org/english/law/crc.htm

We found evidence of training, provided by Homefirst Trust, in specific technical care tasks, (for example, feeding through a tube or administering rectal medicine) and intimate care plans.

We noted that a senior Homefirst Trust manager at a meeting attended by RQIA on 5 July 2006 stated that all Cherry Lodge staff would be trained in managing challenging behaviours, yet this training was not discernible on Barnardo's training programme. It was therefore difficult to ascertain whether or not this training had been considered before the incident in June 2006.

Four members of staff had NVQ Level 3 and three were working towards an NVQ Level 3 qualification. One member of staff had NVQ Level 2.

How were staff relationships at Cherry Lodge?

The overview report submitted to the Review Panel by Barnardo's refers to "relationship problems within the staff team". Three Cherry Lodge staff were suspended in December 2005 "on a precautionary basis" and formal disciplinary hearings were held in July 2006. The disciplinary process was reported as subject to appeal until January 2007. The disciplinary process has now finished. One of the suspended members of staff has left and two are in the process of working with Barnardo's on a plan to help them return to work in another part of the service.

Of major concern were the comments recorded in a quarterly review report, dated 6 December 2005, to the Director of Barnardo's about staff relationship difficulties. It stated:

> "A major investigation is currently underway and is being facilitated by Personnel Unit in Barnardo's. What started out as an apparent difficulty in staff accepting the new Team Leader has turned out to be an extensive and pervasive problem amongst the whole staff group with contracted staff exercising undue control and influence verging on intimidation over others. **The consequences of this have been negative for all staff, particularly relief staff, but most importantly, the quality of care being given to children has been significantly compromised.** Standards of care have declined to a level which is unacceptable. Close monitoring of the situation will be continued and action will be taken if required before the completion of the fact finding exercise if necessary. **The situation in Cherry Lodge is worrying and disturbing."**

What we found

We were concerned to find out that the director of Barnardo's was aware of such severe staffing difficulties since 6 December 2005 and the impact on the quality of care, yet did not implement a full management review and develop a plan to address the difficulties. A hand-written note made on the director's report indicated that a discussion took place about the possibility of help from an assistant director who had experience of similar issues. Barnardo's have confirmed that although this assistant director did provide help, a full review was not implemented at this time.

We have been informed that Homefirst Trust was alerted by a senior Barnardo's manager on 12 January 2006 by e-mail as follows:

> "Initial investigations were undertaken because there appeared to be tensions and difficulties within the staff group. During the course of these, it became apparent there were issues concerning practice. Three main areas have been identified for particular attention in the formal finding of fact. These are in relation to impact on direct work with children; damage to Barnardo's reputation and harassment and bullying of other staff members.
>
> No single incident or untoward event has been identified in the course of the investigation in relation to the direct abuse of a child or young person. The HR staff member conducting the investigation has been briefed to inform me immediately should any such information come to his notice.
>
> The interim position is that the investigation is still underway, though we expect a report by Friday 20 January 2006. The three suspended members of staff have been informed of this. In a verbal report presented to me on Monday 9 January 2006, the emphasis of the investigation has been placed on direct work with children. **Evidence so far indicates some areas of poor performance and standards of care and professional practice at levels we deem to be unacceptable.** No example of direct abuse in relation to an individual child have been revealed.
>
> Once the process of gathering evidence has been concluded and decisions have been made on what action should follow, I will inform you of the outcome. I anticipate I will be contacting you no later than Tuesday 24 January 2006."

However, the Barnardo's senior managers regularly submitted monthly monitoring reports to Homefirst Trust. The October, November and December 2005 reports refer to the staffing relationship difficulties. The December 2005 report states, under the heading "Assessment of quality of care being provided in the Unit":

> "Circumstances are unusual at present because of the investigation that is being conducted and because considerable strain is being experienced by staff having to make up for the absence of three other staff members. Staff are to be congratulated on the way they have been prepared to work extra shifts in order to keep Cherry Lodge running so that individual children and families will not be disadvantaged."

The following appears under the same heading in April 2006 monitoring report:

> "In addition to one member of staff being away on long-term sick leave, three other significant staff members have reported in as unavailable for work because of illness. This has caused considerable difficulty in completing the rota satisfactorily. However, in the short term this has been achieved. Overall, there is a growing awareness among parents that the staff group in Cherry Lodge has become fragile and naturally they are concerned about the ability of Cherry Lodge to deliver the service they have been accustomed to – particularly in the forthcoming summer holiday period. The situation was not helped by the

unavoidable closure of the unit for 72 hours over Easter. It is of paramount importance that a stable staffing situation is established so that confidence can again be restored.

Meanwhile, and on the day of this visit, it was very much business as usual with three staff and three young people enjoying one another's company"

(Homefirst Trust regularly submitted requests for follow-up information from Barnardo's).

Our view was that if senior management in Barnardo's had added together these issues with the previous expressed concerns and the significant events reported in previous monthly monitoring reports, all of the information should have triggered a systematic management review. This would have led to an investigation of practices, training, support and recording issues that have been identified in the RQIA audits prepared for our Review.

One of our most significant findings was that some Cherry Lodge staff reported to the Review Panel that they believed that Barnardo's management suppressed or sidestepped, or ignored, their concerns about unsafe practices in Cherry Lodge and poor standards of care.

They believed that the letter sent to parents informing them of the staff suspensions in December 2005 (see Appendix 12) misrepresented the underlying problems in Cherry Lodge. They alleged the staff difficulties were having a negative impact on the children and a damaging impact on their ability to carry out their jobs. Some staff confirmed this in a letter to Barnardo's management in January 2006. A copy of this letter was submitted to us by Barnardo's in February 2007.

Following a period of positive management, some staff also submitted information to the Director of Barnardo's (NI) expressing concerns about depleted staff numbers and the team's lack of confidence in Barnardo's management. They were concerned that a temporary improvement would not be sustained.

In 2007 some staff still had no confidence that Barnardo's senior management can repair the damage. They have submitted further examples of lack of safe and effective care.

Information submitted to us from a number of Barnardo's employees, from senior management through to current front-line employees, has exposed a very worrying situation of mutual distrust, loss of confidence in Barnardo's management, continuing fear and distrust between members of staff and continued allegations of harassment. Members of staff who were on duty during the weekend of 26 June 2006, and some of their colleagues, continue to be very fearful of the outcome of the police enquiry.

Senior managers from Barnardo's (UK) undertook an investigation during the spring of 2007. At the time of writing, information from that investigation is not yet available.

With the benefit of hindsight, it would appear that what was labelled "relationship problems within the staff team" was a symptom of far wider concerns and should

have been addressed as such. It is notable that since September 2006 two Barnardo's managers, with responsibilities for Cherry Lodge, have also been suspended on a precautionary basis.

In discussion with the Director and Head of Operations at Barnardo's, the difficulties of operating a small unit in a small town became evident to the Panel. The potential for problems when employing a staff team where many of the staff may be related to each other or know each other well outside work must be consciously guarded against.

The Panel have also been told about inappropriate responsibilities being given to relatives and friends of staff members. It was clear that, at times, relatives of staff "helped out" at times of difficulty by for example, fetching medication that had been forgotten or cutting the lawn. There was no evidence that this had been addressed through management processes although some staff reported to the Panel that they had been uncomfortable with these events. We have received the impression of a small close-knit staff team that was not fully understood or scrutinised by external management.

Our remit was not to undertake disciplinary investigations. Indeed, the information that has been presented to us is very contradictory. What was very clear, however, was that the impact of "staff relationship difficulties" on the direct care at Cherry Lodge was not at the time fully investigated by senior management in Barnardo's, nor was it fully followed up by RQIA.

Confidential information gave evidence that there were one or two examples of care practice that did not reach the required standards which were found proven at the disciplinary hearing. This is inconsistent with the written statement in a letter to RQIA on 18 December 2006 from the Director of Barnardo's indicating:

> "No issues regarding any issues of safeguarding or poor practice **were proven** in the disciplinary investigation or hearing."

Scrutiny of records of management meetings and some supervision records indicated that staff relationship difficulties continued throughout 2006. The children's services manager was off sick for a number of weeks, as were other members of staff, so management had the challenge of recruiting enough staff to deliver the service.

However, the most significant finding of the Panel is the repeated outwardly made statement by Barnardo's to all concerned, including the parents, that these staffing problems were having no impact on the delivery of care to the children and young people. However, some parents who attended the meeting with the Review Panel were aware that problems were becoming apparent in Cherry Lodge:

> "There is an issue of continuity of care. As a parent I had to raise details about (my child) with staff five or six times as staff kept changing."

"There are very young inexperienced staff and not many experienced staff. The balance of both experience and qualifications is not there. We assumed everyone was qualified."

"I was shocked that staff were not trained to deal with epilepsy, yet they were on duty. Staff need to be trained..."

"We had concerns about the large turnover of staff in the last couple of years. I thought some of the staff were just there as a means of making a living and didn't seem to have their best attitude to the task in hand."

"There were quite a few so-called incidents that we never knew about, but staff made reports on."

The suspended staff were three out of twenty three contracted staff and had been working at Cherry Lodge for some years. So the question remains as to why more questions were not asked by Barnardo's senior management, Homefirst Trust or RQIA about whether these suspensions were having an impact on the quality of delivery of respite care at Cherry Lodge.

Our findings demonstrate numerous occasions when the practice fell short of that promised in the Cherry Lodge statement of purpose, which Appendix 7 describes. This was not effectively identified by Barnardo's management, by Homefirst Trust or by RQIA,

The Northern Ireland Social Care Council published Codes of Practice for Employers of Social Care Workers and Social Care Workers in 2002[30]. Every social care worker should have had a copy of the Code and every employer should have been raising awareness of the Code and ensuring that the organisation complied with it. The Codes of Practice can be used as part of performance management. (Appendix 13 explains the Code of Practice). The Panel took the view that it could have helped the staff at Cherry Lodge to raise their concerns at an earlier point had they had a greater awareness of the NISCC Code of Practice.

Another publication that organisations may find helpful is Social Care Governance – A Practice Workbook[31] which sets out a model of clinical and social care governance and provides a structured approach to review, agree, implement and demonstrate improvements in practice and service provision.

An assurance was given that: "Barnardo's will advise parents in January 2006 of action to be taken by Barnardo's". There was no follow-up to this letter, presumably because the investigation and subsequent disciplinary proceedings continued until July 2006 and even beyond. The three suspended members of staff should have been registered with NISCC and reported by Barnardo's to NISCC.

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[30] Codes of Practice for Social Care Workers and Employers of Social Care Workers, Northern Ireland Social Care Council, September 2002

[31] Social Care Governance - A Practice Workbook, Social Care Institute for Excellence (SCIE), June 2007. The handbook can be accessed at: http://www.scie.org.uk/publications/misc/governance-workbook.pdf

What we recommend as points for action and self-assessment in how medicines were managed

- Barnardo's, through its Registered Person (a named individual agreed by RQIA as suitable to manage a home) must make arrangements for recording, handling, safekeeping, safely administering and disposing of medicines in Cherry Lodge or any other respite service that Barnardo's provides. These arrangements must address the practice of covert medication and must also build in an audit system to ensure that good practice is complied with.

- Barnardo's should review and improve the training offered to staff in safely administering medication.

What we recommend as points for action and self-assessment in how incidents were recorded and reported

- Barnardo's should review its policies and procedures on reporting incidents and include this in training and development plans for all staff in its services.

What we recommend as points for action and self-assessment in how children's behaviour was managed

- The children attending Cherry Lodge were noted to have varying degrees of learning disability, often accompanied by challenging behaviour. Not all of the children will be able to understand, or take part – or both – in developing a behaviour management plan. Furthermore, it is likely that strategies for intervening physically, including techniques that restrict movement or actions, will be a necessary part of the day-to-day running of the service. It is therefore essential that Barnardo's and Homefirst Trust ensure that appropriate strategies, policies and procedures for the management of challenging behaviour in children are in place. The DHSSPS Guidance on Restraint and Seclusion should be used to inform on these particular issues[32]. The policies and procedures must be used consistently and regularly monitored and reviewed.

What we recommend as points for action and self-assessment in how child protection issues were handled

- Barnardo's should audit how its policies and procedures are practised and implemented in residential and other respite services for children and young people with disabilities. The audit should cover how effective staff training is, and its impact. (We expanded this recommendation to cover other areas in the final section of this chapter).

[32] Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005. It can be accessed at: http://www.dhsspsni.gov.uk/restraint_and_seclusion_august_2005-2.pdf]

What we recommend as points for action and self-assessment in how risk was assessed and managed

- Barnardo's must ensure it has rigorous and effective processes in place, and clear roles and responsibilities, for reporting risk. This should form part of its corporate risk management strategy for any respite services it provides.

- Barnardo's and Homefirst Trust must ensure that risk assessments on every child placed for respite in Cherry Lodge are updated and available to frontline staff. They should jointly agree an audit plan and make this available to all frontline staff to ensure high quality practice in both Barnardo's and Homefirst Trust.

- Barnardo's should quality assure its risk management reporting systems and structures.

What we recommend as points for action and self-assessment in how staff were supervised

- Barnardo's should review, as a priority, its policies and procedures for supervising staff, and audit how they are implemented, in line with the Code of Practice for employees and employers, as set out by the Northern Ireland Social Care Council.

What we recommend as points for action and self-assessment in how Cherry Lodge was monitored

- Barnardo's should review its corporate governance arrangements and audit how its policies and procedures are practised and implemented in residential and other respite services for children and young people with disabilities. The audit should cover:
  - recording systems;
  - assessing and managing risk;
  - effectiveness and impact of staff training;
  - supervision;
  - systems to avoid collusion when operating with a small, close-knit staff team.
  - working with other agencies such as boards and trusts; and
  - the extent to which managers effectively monitor their services.

- Barnardo's should ensure as a minimum that its monthly monitoring report addresses the elements set out in Appendix 1 of Quality Living Standards for Services: Children who live away form home (Children Living in a Children's Home).[33] Barnardo's annual report should address as a minimum the elements set out in Appendix 2 of that publication.

[33] Quality Living Standards for Services, Children who live away from home(Children Living in a Children's Home) SSI, DHSS, 1996

Chapter 6: A review of RQIA's inspection process and how it monitored quality

This chapter sets out:

- **Why we wanted to review RQIA's inspection process and how it monitored quality**
- **How RQIA inspects children's homes**
- **Did RQIA seek the views of residents, relatives and others?**
- **Seeking parents' views: what we found**
- **Seeking children's views: what we found**
- **What our review found on RQIA inspection reports and monitoring of quality from August 2005 - August 2006**
- **The background to RQIA's agreement to an emergency admission to Cherry Lodge**
- **How RQIA monitored management, training and supervision**
- **How RQIA monitored supervision and appraisal**
- **How RQIA commented on training provided by Barnardo's**
- **How RQIA monitored the impact of staff suspensions and absences**
- **How RQIA monitored quality of care**
- **How RQIA monitored adherence to the statement of purpose**

Our recommended points for action and self-assessment are listed at the end of the chapter.

Why we wanted to review RQIA's inspection process and how it monitored quality

RQIA regulates all children and adult residential care homes in Northern Ireland and has inspected the Cherry Lodge respite service.

We asked a senior inspector from the Care Standards Inspectorate for Wales to assess how effectively RQIA had undertaken its statutory role as regulator of this service. We did this so that RQIA could maximise what it learned from this incident. We asked the inspector to:

- identify any omissions in regulatory practice;
- offer professional comment on these omissions; and
- suggest any improvements required.

These observations and views on RQIA's performance were solely based on the inspections carried out at Cherry Lodge from the 1 August 2005 to 1 August 2006.

The standards used by the inspector to benchmark practice were from a grid drawn up by RQIA of expected inspection practice. This grid has been referred to earlier and is available from RQIA on request. The grid uses:

- The Social Services Inspectorate Quality Living Standards for Services: Children who live away from home[34] (Children Living in a Children's Home).
- The current Children's Homes Regulations (Northern Ireland) 2005[35]

In addition, the comments in this chapter were made with reference to the expected practice of inspectors from the Care Standards Inspectorate in Wales.

The Chair of the Review Panel, in her role as Chief Executive of the Care Commission in Scotland, also gave her opinion on the way Cherry Lodge was inspected during this time.

The inspector also examined a range of other information, including RQIA files and inspection reports covering the review period and correspondence records from Cherry Lodge and others to RQIA.

How RQIA inspects children's homes

In Northern Ireland the Regulation and Quality Improvement Authority (RQIA) is required under The Children (Northern Ireland) Order 1995[36] to inspect all residential children's homes twice a year. One of these inspections is announced and one is unannounced. This legal requirement is set out in The Children (Northern Ireland) Order 1995 and in The Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005[37].

Every residential home, under current practice, has an announced and an unannounced annual inspection. Announced inspections normally take two to three days to complete.

During the announced inspection, one lead inspector is responsible for co-ordinating the information for the final report from the other inspectors, who are involved in specific areas of the inspection, for example pharmacy, estates or finance.

The inspectors also carry out an unannounced inspection, which normally takes one day. This can take place out of normal working hours, including early mornings, late evenings and weekends. No advance notification is given. The primary focus of the unannounced inspection is to:

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[34] Quality Living Standards for Services, Children who live away from home(Children Living in a Children's Home) SSI, DHSS, 1996

[35] The Children's Homes Regulations can be accessed at:
http://www.opsi.gov.uk/sr/sr2005/20050176.htm

[36] The Children (Northern Ireland) Order 1995 can be accessed at:
http:/www.opsi.gov.uk/si/si1995/Uksi_19950755_en1.htm#tcon
The Explanatory Note can be accessed at:
http://www.opsi.gov.uk/si/si1995/Uksi_19950755_en_55.htm#exnote

[37] The Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005. The Regulations can be accessed at:
http://www.opsi.gov.uk/sr/sr2005/20050182.htm

- follow up on previous requirements and recommendations which have been made about the care home; and
- obtain a snapshot of care practices.

Did RQIA seek the views of residents, relatives and others?

Cherry Lodge is a registered children's respite care home; its statement of purpose says it "...works in partnership with children, parents and other professionals." (Appendix 7 has more details about the statement of purpose). However inspection reports do not indicate that RQIA tested these claims. Nor was there a full assessment of whether the service was fulfilling its statement of purpose. Young people and their families who use respite services are entitled to be given information about what constitutes safe and effective care and their opinions on service delivery should be sought.

RQIA carried forward a recommendation made initially in reports following the announced inspection of 2005 and the unannounced inspection in February 2006 that some form of user survey should be introduced. This survey would presumably target the parents of service users. RQIA requested that Barnardo's provide RQIA with a copy of this survey questionnaire, but there was no evidence in the inspection file if this was ever received or the recommendation followed up.

RQIA stated in both the announced and unannounced inspection that a range of methods had been used to gather information about the care home, including taking into account "the views and opinions of residents, relatives and others".

There was no evidence in the inspection file to verify this had happened. Our independent inspector concluded from the evidence in the files that the inspectors had relied heavily on examining documents and systems and had not balanced this approach sufficiently by talking to young people who used the service, their families and staff.

Seeking parents' views: what we found

Copies of a stock letter on the RQIA file indicated that questionnaires were sent to ten parents in September 2005 notifying them of an imminent inspection. The September 2005 inspection report then indicated that nine parents of children using the service did give their views to RQIA in returned questionnaires. The former inspector recalled seeing these views. The report stated that these predominantly show confidence in the service, but copies of these were not available on file. There was no evidence of a reply on file from any of those written to. As a result, we are unclear how these views were given, by whom and when.

All parents at our meeting in November 2006 appeared to value the Cherry Lodge service highly, even if all were not currently using the service, and many made positive comments.

Seeking children's views: what we found

During an inspection, the views of children who are using the care home should be sought. Standards 7.3, 8.7 and 8.15 from the SSI Quality Living Standards for Services: Children who live away from home invite inspectors to do this. No commentary was recorded to indicate whether or not these standards were met.

In the inspection paperwork the statement against Standard 7.3 on children's rights suggested that children need appropriate assistance in expressing an informed view. There was no written evidence to confirm that these views were made known to the inspector. It was recorded in the inspection report that: "children have a limited understanding of these concepts".

In the September 2005 announced inspection report, the inspectors stated they found high levels of competency amongst staff in the use of alternative means of communication systems with children at Cherry Lodge. Given these systems were reported to be in place, it appeared that children were still not routinely consulted as part of the inspection process.

The Barnardo's annual monitoring report on Cherry Lodge 2005-2006 stated that children are encouraged to contribute to their own reviews. No recorded evidence was available to indicate this practice occurred. Reports did not identify how effectively staff at Cherry Lodge or visiting professionals consulted with children on an individual basis about choices and decisions. The Barnardo's annual monitoring report also gave views from professional staff visiting Cherry Lodge. There was no discernible evidence that RQIA has verified the quality and quantity of monitoring by other Cherry Lodge stakeholders.

Homefirst Trust declared in its corporate parenting report that robust governance measures were in place, although deficiencies in Looked After Children arrangements have already been identified elsewhere in this report as a concern. The Northern Health and Social Services Board clarified that although Homefirst Trust did not have parental responsibility for looked after and accommodated children for respite, it would still expect the corporate parenting report to include a section on these children.

The Northern Health and Social Services Board indicated in its response to the Review Panel that it relied on RQIA inspection reports as part of its system of quality assurance. Our review identified shortcomings in the investigative depth in RQIA's inspection methodology with Cherry Lodge, and a lack of supervision of care input from Homefirst Trust. This flags up the need for a review by RQIA of inspection practice but also a need for each agency, including the NHSSB, to have internal or external systems in place to monitor the performance of the services they contract.

What our review found on RQIA inspection reports and monitoring of quality from August 2005 - August 2006

We reviewed RQIA inspection reports for Cherry Lodge from August 2005 - August 2006. There was an announced inspection in September 2005 and an unannounced inspection in February 2006. In general, they described the service provided by

Cherry Lodge, but did not fully evaluate standards of care against the SSI Quality Living Standards for Services: Children who live away from home. (see footnote 33 page 53)

Incidents of repeated concerns about the same children were received by the inspector through the untoward incident reporting system, but there is no record indicating the inspector's review of this information with Barnardo's or the Trust. No evidence was available to indicate that RQIA examined or commented on the detail contained in incident records during this review period to identify, comment or follow up on the issues of concern that were identified.

In most areas inspected at Cherry Lodge up to February 2006 RQIA rated Cherry Lodge as having met standards in full. The September 2005 inspection and the unannounced inspection of February 2006 indicated records were reviewed and found to be in order unless otherwise stated. There was no comment about the quality of recording noted in the inspection report.

A separate pharmacy inspection of Cherry Lodge took place on Thursday 23 November 2005 and identified shortcomings with the way medication was administered. RQIA made requirements for the care home in this area and a written response from Cherry Lodge in January 2006 confirmed that it had taken action. The RQIA files contained very little information about any contact with Cherry Lodge between inspections by the care inspector, despite RQIA receiving untoward incident reports about the administration of medication.

It would be expected that the outcome of the pharmacy inspection should have been taken into consideration in terms of the main inspection activity at Cherry Lodge. There was no evidence to indicate that pharmacy inspection was informed by, or informed, the main inspection activity at Cherry Lodge.

It would be expected also that any contact by the inspector with homes throughout the inspection year, in whatever form, was recorded and kept on file. We were unclear whether no contact was made or whether it was not recorded.

Each month, Barnardo's produced a monthly monitoring report for Cherry Lodge. It also produced a monthly assessment of quality of care. Both these documents were sent to the RQIA as part of the standard monitoring process.

We had no indication that RQIA was in contact with Barnardo's about the quality of their monthly monitoring reports for Cherry Lodge and the monthly assessments of quality of care.

Monthly monitoring reports were available on file for June 2005, July 2005, August 2005. The reports indicated that standards were being consistently achieved in all aspects of the service, including maintaining the incidents book. Where information on untoward incidents had been provided to RQIA by Cherry Lodge there was no evidence of how RQIA had responded to this information, or if child protection procedures had been followed in the few cases identified as part of this review process.

In our view the assessments by RQIA about the quality of care being provided at Cherry Lodge provided little or no criticism of the service, until April 2006, when the Barnardo's monthly monitoring report for April 2006 sent to RQIA refers to a "... growing awareness among parents that the staff group in Cherry Lodge has become fragile..." The monthly monitoring report for June 2006 referred to extra staff being engaged. These assessments were signed off by two senior managers in Barnardo's but it is unclear if any further action was agreed with the inspector to ensure continuing staff stability and safe practice.

A critical incident review report completed by an assistant director in Barnardo's in October 2006 stated: "from accounts of staff and review of records there was evidence of deficits in a range of standards within Cherry Lodge".

The report added that this included:

- child protection and safeguarding standards;
- recording standards;
- risk management standards;
- behaviour management standards;
- handover systems;
- the review and assessment of the group-mix of children;
- shift leadership;
- reporting information to and seeking advice from on-call staff;
- seeking and receiving approval to leave shift early; and
- administering medication to children and young people.

What was clear from this review was that RQIA must always validate the information it receives and carry out random checks on the evidence that is being presented.

The background to RQIA's agreement to an emergency admission to Cherry Lodge

The roles and responsibilities of RQIA's staff have changed from those of the former Registration and Inspection Units managed by each of the four Health and Social Services Boards. At the time of this change, RQIA agreed that Y could be placed at Cherry Lodge after their 18th birthday. This was due to the fact that no immediate respite option was available within Homefirst Trust. This agreement was set out in a letter from RQIA dated Wednesday 31 May 2006 to Homefirst Trust.

As stated previously, Y had stayed in Cherry Lodge on many previous occasions and was well known to staff and other children.

Barnardo's did assess Y's needs and the associated risks and these were discussed by the inspector with the home's manager and her line manager before the placement was made.

This inspector told us a discussion was held with the staff from Homefirst Trust. They felt Y's needs had been reviewed and the placement was agreed as an emergency, as long as the Trust immediately started work on a transition plan for Y.

The discussion was not about a variation in the registration status of the home or about changes to the Statement of Purpose. Rather it purely related to a one-off placement for Y. It was therefore inappropriate of RQIA to be involved in making this decision about the placement as it is the responsibility of the placing authority and service provider to assess how they can meet the young person's needs and assess any risks.

This practice has now stopped after RQIA issued guidance to staff. The regulator should not be involved in decisions like this and this is now accepted practice at RQIA.

How RQIA monitored management, training and supervision

During any care home inspection, inspectors should gather evidence about training, staff morale, recruitment procedures and how managers support their staff.

The 2005 announced inspection report identified that the manager of Cherry Lodge was not available one day a week. This situation arose as the manager was working with another Barnardo's service on that day, in an agreed internal arrangement.

There was no evidence that RQIA examined or monitored the potential impact on consistent management at Cherry Lodge because of this absence.

A senior project worker had been employed to enhance the staff team and, it appeared, to provide a senior presence when the manager was away.

RQIA had made a recommendation that Barnardo's monitor this arrangement but no evidence was recorded to show that RQIA checked this was happening.

RQIA was notified on 18 August 2005 that Barnardo's had appointed a Children's Services Manager at Cherry Lodge. Letters requesting references were sent out by RQIA on 28 September 2005 to referees. The RQIA files contained no response from these potential referees, nor any record of the Children's Services Manager's application, a records check with the Protection of Children and Vulnerable Adults (POCVA) Team, interview and outcome on suitability for registration. The POCVA check was later found in a separate file and we were unsure if other documents would also have been filed separately in RQIA. The inspector should have put in writing that the file was checked to confirm effective recruitment procedures were in place and recorded this on file.

How RQIA monitored supervision and appraisal

Barnardo's annual monitoring report indicated that:

"staff and the manager were supervised monthly and appraised annually".

It also stated that the manager's performance was reviewed every three months. Inspection reports did not confirm that RQIA validated a sample of these arrangements or scrutinised the care home's supervision and appraisal records.

Inspection reports did not specifically indicate that documents such as staff supervision notes, appraisals and training records (which were subsequently provided to us) had been taken into account during the inspection.

More in-depth inspection would have identified, as we now know, that supervision and appraisal were more erratic and inconsistent than measured and consequently of limited value as a way of supporting staff effectively.

RQIA reports did not contain a statement about the standard and effectiveness of leadership at Cherry Lodge. A view should have been formed from interviews with a random selection of staff in confidence and in private, for example, from a manager, experienced, new, senior, full-time and part-time staff. The inspector should also have scrutinised a sample of staff files to make sure that effective supervision, appraisal and relevant key training were all in place.

How RQIA commented on training provided by Barnardo's

We would expect that inspectors should routinely seek evidence that staff in children's homes have the necessary experience and skills to enable them to meet the specific needs of children using the services effectively. The inspection reports on Cherry Lodge did not provide clear evidence on how the experience and skills levels of staff were verified.

In the Barnardo's monthly monitoring report in 2005, staff asked for training on language and techniques to be used in addressing sexualised behaviours with children. There was no evidence of any follow-up on this by either Barnardo's, the Trust or RQIA.

The RQIA report from the announced inspection in September 2005 recommended that staff should receive child protection refresher training and fire safety training. The unannounced inspection report of February 2006 stated that these matters had been addressed and recorded that child protection training had taken place in October 2005.

RQIA reports referred to staff training but made no comment on the content or quality of the training programme, or if the training they provided was appropriate to the task of working with children who challenged the service. There was no record of RQIA seeking a view from staff at any time about the training which they considered they required to develop skills in working with children with disabilities.

Noticeably absent was specific and relevant training for staff in behaviour management using physical intervention and the development of awareness and skills in learning disabilities. There was no evidence to indicate how the new members of staff starting after October 2005 received this important training.

The staff training programme and record for Cherry Lodge identified sixteen staff who took part in training. Training on offer covered a small range of topics, for example moving and handling, first aid, and essential food hygiene. Some basic healthcare training was also available, such as oxygen therapy and suctioning.
In Northern Ireland the qualification for managing children's homes is a social work

qualification. The home manager did have the appropriate qualification.

Of the sixteen staff identified earlier, only four had attained NVQ Level 3 and one member of staff had attained NVQ Level 2.

No comment was made in inspection reports about whether Barnardo's set any training targets for its staff in this regard or how the service inspected was working to achieve any type of training plans or qualifications targets. The inspector was satisfied that Barnardo's was committed to investing in its staff.

From 1 June 2005 the Northern Ireland Social Care Council (NISCC) required all staff, qualified and unqualified, who worked in children's homes to register with the Council. There was no evidence that RQIA had checked that Barnardo's was complying with NISCC's Employer's Code.[38] This Code required Barnardo's to ensure that the staff were registered.

How RQIA monitored the impact of staff suspensions and absences

The suspension of three members of staff in December 2005 could have had serious implications on the service's ability to continue to deliver a safe and effective service.

It appeared that RQIA accepted the statements made following meetings between Homefirst Trust and Barnardo's that the quality of care at Cherry Lodge had not been impaired by the activities of these staff. However, as the next chapter identifies, RQIA did not seek to get these assurances verified by Homefirst Trust.

Nor did RQIA establish that robust monitoring was in place to make sure the same level and quality of service was being offered.

No evidence was on file to indicate that RQIA had verified Barnardo's actions following the suspension of staff.

RQIA attended meetings convened by Barnardo's and Homefirst Trust after the suspensions. Reports sent to the Panel by Barnardo's revealed that there was some evidence of poor practice by staff who were suspended.

- The reports dealt with bullying of staff, though no record existed on file that RQIA sought to establish the reasons for the three suspensions at the time.
- The unannounced inspection report of February 2006 alluded to the response by Barnardo's to the suspensions, but there was no evidence of this being verified by RQIA in the RQIA file in terms of any scrutiny made by Barnardo's.
- There was no recorded evidence that RQIA followed up the outcome of the disciplinary decisions and the management plan for these members of staff in the context of the safety and well-being of children in any settings where they might have been employed.

[38] Codes of Practice for Social Care Workers and Employers of Social Care Workers, Northern Ireland Social Care Council, September 2002

Following the suspension of staff in December 2005 and the allegations relevant to 27 June 2006, RQIA should have insisted on seeing a risk assessment of:

- the impact on the service as a result of staff changes; and
- how the provider planned to maintain a safe environment for children.

As with Homefirst Trust, RQIA relied on Barnardo's conducting a thorough investigation and Barnardo's assurance that the investigation had no implications for the delivery of safe and effective care. The RQIA inspector's view was that Barnardo's should be given the time to complete its internal investigation and report back. It was not satisfactory that the process took so long.

We were advised by the inspector that a telephone discussion was held with the team leader and her line manager at the beginning of April 2006. A verbal assurance was given to the inspector on the issue of staffing, including the increased direct supervision planned by the team leader. No assurance was sought about the adequacy of the staffing arrangements and no record was found of this dialogue.

Barnardo's monthly monitoring report of 31 July 2006 noted that one member of staff had been off for over three months and one for over four months. Nothing is recorded on file to indicate that RQIA identified the impact of these missing staff or action taken to cover their shifts.

How RQIA monitored quality of care

There was evidence that RQIA sought and commented on three Barnardo's internal day-to-day care plans in use at Cherry Lodge. There was little comment made about how these care plans reflected the requirements of the child's placement plan. No comment was made in RQIA reports about the absence of LAC plans, nor was comment made about how a valid and safe care plan could be produced without key information from the placement plan. Reports do not clarify that RQIA scrutinised care plans and reviews to form a view about whether assessed need could actually be met by the service.

There was no recorded evidence that RQIA had closely examined a sample of records of children using the service, or confirmed that alternating six-monthly LAC and Cherry Lodge reviews was inappropriate under the existing legislative requirements, given that Homefirst Trust should have conducted these reviews six-monthly.

There was no evidence or comment about how RQIA reviewed the Cherry Lodge protocols and guidelines on the mix of children using the service at any one time, bearing in mind the challenging behaviours evidently presented by certain children using the service.

Qualitative comment should have been made in the inspection report about the standard of multi-disciplinary risk assessments in view of the variety of children using the service and of any ongoing review of these risk assessments. This presumably would have identified the shortfalls already described in the file audit undertaken of Homefirst Trust files.

In general terms the inspection process used by RQIA did use systematic measures to judge Cherry Lodge service against contemporary regulations and SSI standards for children living away from home. The inspection reports, however, gave the impression that most validation criteria were judged to have been met in full and may well have reflected a well-performing and safe operation.

Much was reported to be in place at Cherry Lodge, for example recording systems, incident records, children's files and staff files. But little evidence was available of how the quality of this information was scrutinised or whether more creative methods (other than the set standards format) were used to gather information and establish fact.

The RQIA should now review these findings in the development of its new inspection methodology.

How RQIA monitored adherence to the statement of purpose

An integral part of the inspection process should be to verify that the service is operating within and meeting the remit of its statement of purpose and that the statement accurately reflects what the service sets out to do.

One of the aims of both the announced inspection of 26 and 27 September 2005 and the unannounced inspection of 28 February 2006 was to determine the extent to which the home's statement of purpose had been achieved.

No definitive comment was made that the home was operating within the remit. Subsequent action taken by Homefirst Trust and Barnardo's during the independent review period identified: "...that Cherry Lodge was no longer an appropriate placement.....for a number of children...". This would suggest that the inspector should have taken a more in-depth look at whether or not the service was actually complying with its statement of purpose.

This puts into question the effectiveness of the original assessment of these children and the appropriateness of their placement in the context of Cherry Lodge's statement of purpose. This has now been reviewed and a reassessment of the needs of the children being admitted to Cherry Lodge has been undertaken by the Trust in conjunction with RQIA. The service was stopped temporarily while new arrangements were put in place.

What we recommend as points for action and self-assessment

- RQIA should ensure that requirements and recommendations issued as part of its reports are met within an agreed timeline with the provider and take regulatory action if this is not the case.

- RQIA should review the current systems in place to report how children, families, staff and other stakeholders actively take part in the way they regulate services.

- Inspectors should consider using case-tracking to audit children's individual experiences, for example, from when they are first assessed and referred to a service, to how they are introduced to the service, how their care is planned and how their transition to adult services is managed when they are eighteen.

- RQIA inspectors should monitor and report on whether codes of conduct for employers and staff are being complied with, as set out by their regulatory bodies' codes of practice (NISCC).

- RQIA inspectors should review and comment on the adequacy of training provided in view of the home's agreed statement of purpose and report on whether the training is being put into practice.

- RQIA should systematically check incident records when it is carrying out an inspection. If inspectors identify trends, they should check that care providers and managers and those commissioning care are aware of these trends and have taken appropriate action if necessary to safeguard and protect children and young people.

- RQIA should review its records management system including how information is shared between inspectors.

- If RQIA is notified of significant changes in staff or in the provider's ability to provide safe and effective care, it should make sure the care provider has:

  - carefully assessed the risks of the situation;
  - drawn up a robust action plan;
  - shared this plan with all organisations involved in the care they provide; and
  - assessed any potential impact on the children it cares for.

- RQIA should consider how they prioritise caseload management on the professional supervision agenda with all inspectors, as a means of quality assurance by RQIA managers.

- RQIA should develop a system so peers and lay people can be part of its inspection processes, comparable to that used in its clinical and social care governance review process.

- RQIA managers should find a way to establish that all inspectors are analysing the perceived performance of a service before they inspect it and then pitch the intensity of their inspections proportionately. Such a process would, together with sampling of inspection reports by managers and validating information received, ensure the new inspection methodology was successfully implemented.

- The Review Panel concluded that RQIA should agree a Memorandum of Understanding with the five new Trusts and the Strategic Health and Social Services Authority on how they share information from inspection reports,

investigations and reviews. This is the position in Scotland and Wales. It may be, however, that the recommendations in Our Children and Young People – Our Shared Responsibility[39] about how inspection reports should be shared will address this issue.

[39] Our Children and Young People - Our Shared Responsibility, Inspection of Child Protection Services in Northern Ireland, Social Services Inspectorate, DHSSPS, December 2006

It can be accessed at: http://www.dhsspsni.gov.uk/oss-child-protection.htm

Chapter 7: Review of governance and monitoring arrangements of the Northern Health and Social Services Board (NHSSB) and Homefirst Trust

In this chapter we consider:

- **The Northern Health and Social Services Board**
  - **Background to how the NHSSB commissioned services**
  - **The NHSSB's duty of quality**
  - **What was expected of executive and non-executive directors of Boards and Trusts?**

- **Homefirst Trust**
  - **How Homefirst Trust monitored quality**
  - **How the Trust applied its Looked After Children (LAC) processes**
  - **Information provided to us by Homefirst Trust about how it monitored the quality of service**
  - **Homefirst Trust's 27 October 2006 report on monitoring LAC review processes**
  - **Corporate processes**
  - **Barnardo's monthly and annual monitoring reports to Homefirst Trust**
  - **Staff training**
  - **Monitoring the quality of the service level agreement**
  - **POCVA checks**
  - **Staffing structures and ratios**
  - **Response to incident reporting**
  - **Systems for assuring quality**

Our recommended points for action and self-assessment are at the end of the chapter.

The preceding chapters have indicated deficits in information and practice. There is also a considerable body of evidence supporting the need for respite services for children with learning disabilities and the fact that families can find it extremely difficult to access respite (see Appendix 8). The Review Panel therefore spent some time examining how the NHSSB and Homefirst Trust commissioned and monitored respite services.

When we spoke to families, it was apparent that it was difficult for them to understand the responsibilities and reporting arrangements of the various organisations involved in commissioning, monitoring and providing services. The chart in Appendix 14 attempts to explain this.

The Northern Health and Social Services Board

Background to how the NHSSB commissioned services

The NHSSB provided the Review Panel with information which explained that the population of the NHSSB area is 430,506, which includes 111,500 children and young people under 19. At the time of the review, the Board was responsible for

commissioning services in line with the identified need of its population. Effective commissioning ensures that services respond to need and are consistently of high quality in line with regional and local priorities, and effective and efficient care.

Organisations that commission services are expected to enhance the quality of life of children, young people, their families or their carers. They do so by seeking to improve services and making the best use of the resources available to them – such as staff and funding – to meet the needs and aspirations of those who use the services. They link financial and service planning with effective working partnerships.

The NHSSB was also responsible for:

- Approving the Trust's scheme for delegation of statutory functions (legal responsibilities) and related professional and other quality standards;
- Approving the policies and procedures that Health and Social Care Trusts use to deliver these statutory functions; and
- monitoring and evaluating – in ways agreed with the Trusts – how services are provided to the people who use them.

The NHSSB's duty of quality

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[40] imposed a legal duty of quality on Boards and Trusts. This meant that each organisation was legally responsible for satisfying itself that the quality of care it commissioned met the required standard.

This had major implications for monitoring and auditing children's services. It strengthened existing requirements as set out in circular HPSS/PPRD5/5/94, Circular METL2/94 and Circular CC03/02[41].

All Trusts in Northern Ireland must provide a corporate parenting report every six months to their Trust Board. Similarly, officers of Boards must provide a corporate parenting report to the Board Directors. The reports must provide evidence that the organisations are complying with their legal duties and highlight important issues of concern. These in turn, should be submitted to the Department of Health, Social Services and Public Safety (DHSSPS).

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[40] The 2003 Order can be accessed at: http://www.opsi.gov.uk/si/si2003/20030431.htm
The Explanatory Memorandum to the 2003 Order can be accessed at:
http//www.opsi.gov.uk/si/si2003/03em0431.htm

[41] DHSSPSNI Circular HPSS/PPRD/94; DHSSPSNI Circular METL 2/94; DHSSPSNI Circular CC03/02, Roles and Responsibilities, June 2003. These Circulars set out the statutory requirements on Boards and Trusts and explain the rules and responsibilities of Trust Directors in relation to the care and protection of children in their areas.

In March 2006 the DHSSPS published Quality Standards for Health and Social Care[42] to further improve good governance and best practice in the health and personal social services.

The standards have five quality themes:

- corporate leadership and accountability;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social well-being; and
- effective communication and information.

We used these standards to assess the quality of care provided by Homefirst Trust and NHSSB.

The NHSSB and all other organisations were expected to ensure that visible and rigorous governance arrangements were in place. The Board had to ensure there were structures, processes, and clearly defined roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in how health and social care services are provided.

We noted many positive aspects in the Board's governance arrangements for social care and clinical care (which is, for example, care in hospital, or by doctors or nurses).

The Board's children's services planning (CSP) arrangements evidently contributed to how they assessed overall need and commissioned services. The many reports the Board submitted to us indicated a high level of activity aimed at protecting vulnerable children and families. The Board demonstrated a comprehensive system of gathering information, assessing risk, managing how the system works and planning investment. The system should mean that deficiencies in services are identified, reported on and, in specific cases, monitored.

The Board and Homefirst Trust set up a Service and Budget Agreement covering the period 1 April 2005 - 31 March 2008. This set out how the two organisations should work together as service purchaser (the Board) and service provider (the Trust).

Under the agreement, the two organisations shared information of mutual interest, information about anticipated financial pressures and matters of professional, public or of political concern that may need joint action or response.

It also put in place clear reporting structures for ensuring high standards of clinical and social care and arrangements for monitoring and reviewing, through the:

- Trust child protection panel;
- Trust's six-monthly report on their corporate parenting responsibilities;

[42] The Quality Standards for Health and Social Care - Supporting Good Governance and Best Practice in the HPSS, DHSSPS, March 2006

- Annual discharge of statutory functions report; and
- Annual quality report on children's homes.

What we found

It is clear from reports submitted to us that monitoring was carried out. It occurred through regular reports to senior Board officers in individual disciplines and through regular formal meetings to monitor the service and contract. These meetings involved senior officers from the Board and the Trust. These parallel processes provided an opportunity to have a continuous overview of pressures and priorities so that emerging difficulties could be quickly identified and addressed.

It is through these arrangements that the Board commissioned, through Homefirst Trust, a respite service from Barnardo's. While the Trust was legally responsible for delivering the service to appropriate standards, the Board remained legally responsible for ensuring the Trust had in place the necessary arrangements to effectively deliver the service to the expected standards.

We would have expected, in the context of the quality standards framework, the Board to have made sure that thorough and effective systems were in place to review the quality of the services they commissioned. This was reflected in the Board's review of Homefirst Trust's statutory functions report of 2005-2006.

What was expected of executive and non-executive directors of Boards and Trusts?

Those who serve on Health and Social Services Boards (and the Boards of Trusts) were expected to be clear about their responsibilities for children's services and the contribution required by them as executive and non-executive Directors. This is outlined in the DHSSPS Circular CC03/02. (see footnote 41 page 68)

In terms of governance – that is, the structures, processes, roles and responsibilities for providing care services – their main responsibilities were to ensure that:

- meeting legal child protection duties remained a priority for the organisation;
- the services the organisation provide are effectively monitored against core standards; and
- appropriate enquiries and investigations are commissioned when there are concerns about shortcomings.

When the Board delegated statutory functions (legal duties) to Homefirst Trust, it should have held the Trust to account for:

- how it performed its duties and functions;
- delivering the aims and results that are required for children's services;
- reporting on how it is performing and delivering.

What we found

The Board had many systems and procedures to monitor the services it commissioned. But there was insufficient evidence of thorough and effective monitoring or audit of how Homefirst Trust was performing its legal function of reporting in the specific areas of:

- pre-admission planning and care planning;
- LAC reviews or;
- visiting.

The Board provided an annual report to the Department of Health and Social Services and Public Safety in which it detailed its performance and that of Trusts in delivering the Board's legal duties. The table below, which is taken from that report, shows the number of children accommodated in respite care in the NHSSB and compares it with other Board areas.

Table 1: Children accommodated for respite care 2003 - 2006

Board	02/03		03/04		04/05		05/06	
	Number	**Rate [1]**	**Number**	**Rate [1]**	**Number**	**Rate [1]**	**Number**	**Rate [1]**
Eastern	259	15.4	264	15.7	320	19.1	353	21.0
Northern	366	32.8	354	31.8	401	**36.0**	167	**15.0**
Southern	139	15.6	154	17.2	170	19.0	170	19.0
Western	85	10.2	86	10.4	92	11.1	95	11.4
Northern Ireland	**849**	**18.8**	**858**	**19.0**	**983**	**21.8**	**785**	**17.4**

Source: LA5

[1] Rates are per 10,000-population aged under 18 based on the 2001 census figures.

It was evident from this report that the number of children receiving respite in the Northern Board area fell significantly from 2004-2005 to 2005-2006. The Panel acknowledged that there was more than one Trust in the Northern Board area and that this table shows all accommodated children. Nevertheless the Trust's corporate parenting reports and the CC03/02 corporate parenting reports did not provide evidence to explain this. The reason for the dip was not specifically referred to in the Homefirst Trust's corporate parenting report or raised by Board officers when the report was presented to the Board.

Homefirst Trust corporate parenting reports raised issues of children's needs for respite services and placements not being met. This showed there were continuing shortfalls in the ability to provide sufficient respite for families with children with a disability.

Under the Children's Services Planning Order (1995) the NHSSB specifically reviewed services provided in its area under Part IV of the Children (NI) Order 1995[43]

[43] The Children (Northern Ireland) Order 1995 can be accessed at:
http:/www.opsi.gov.uk/si/si1995/Uksi_19950755_en1.htm#tcon
The Explanatory Note can be accessed at:

and prepared and reviewed their plans in the light of this. This planning process is normally used to influence the Board's priorities and to allocate resources, such as staff and funding.

However it was noteworthy that, despite this planning process, the NHSSB did not have an overall specification for providing the complex range of services that the Board commission for young people and their families.

The Board's arrangements for monitoring contracts and their overview of Homefirst Trust, identified the Board's concerns about the extent and severity of the Trust's failure to perform statutory duties[44]. The Board's analysis of how Homefirst Trust was performing its legal duties indicated:

> "a significant improvement was made in the quality of information provided to the Board".

The Board stated that there were still major gaps in areas of

> "essential reporting of functions in the Homefirst Trust's annual statutory function report".

This resonates with findings in Our Children and Young People - Our Shared Responsibility[45] in which the importance of information provided by Trusts is stressed in relation to Child Protection Services. This Social Services Inspectorate report refers to the importance of Boards being able to validate and analyse Trust information to inform service planning and commissioning.

The Trust stated that the reporting gaps were because the Department of Health and Social Services had issued no guidance in some areas because definitions of what should be reported were unclear. The Trust should however have been complying with what the Board required in relation to the Trust demonstrating how it was carrying out its legal duties. In relation to guidance about what should be reported, the DHSSPS informed the Review Panel that work is now underway to produce a regional reporting framework.

The Board reported that the Trust's corporate risk register did not include all the risks that the Trust identified in its statutory functions report. The Board reported that inconsistent attitudes and processes were evident. The Board, appropriately, identified that Homefirst Trust social services directorate and the Board's corporate risk register "may need to be reviewed in the light of the report received from the Trust".

The Board – also appropriately – highlighted that legal requirements in assessing the needs of and providing services to carers had not been followed. No evidence was

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http://www.opsi.gov.uk/si/si1995/Uksi_19950755_en_55.htm#exnote

[44] Overview Report from NHSSB of Trusts Discharge of Statutory Functions Report, October 2006

[45] Our Children and Young People - Our Shared Responsibility, Inspection of Child Protection Services in Northern Ireland, Social Services Inspectorate, DHSSPS, December 2006

presented to us of the Board seeking any validation of the Trust's controls assurance systems for Looked After Children. Had this been evident some of the issues raised by this review in relation to the monitoring of Looked After Children may have come to the attention of the Board and the Trust earlier.

The Board Director of Social Services and the Trust Director of Social Work met on 31 May 2006. The Board acknowledged that although Homefirst Trust corporate parenting reports had improved "in data quality presentation and readability, there was a need for Homefirst Trust to move to look more closely at the concept of 'benchmarking'".

Homefirst Trust submitted their 2004/2005 annual monitoring report for their residential care services to NHSSB in April 2006. Cherry Lodge featured in some sections of this report but was not included in other significant areas of reporting, for example, staffing and untoward incidents. It is unclear whether this was because of the size of the service or the fact that it was a respite service. The Panel found the small number of references to Cherry Lodge concerning, given:

- that the Board was aware of the growing demand for, and pressures on, this respite care service; and
- the difficulty in meeting parents' expectations reported to the Board by Homefirst Trust.

Under the governance arrangements we would have expected the Board to have ensured Homefirst Trust had feedback on its overview report on its children's homes services. The Board provided evidence that it wrote to the Trust in January 2006 when first alerted to the earlier suspension of three staff. In the letter, the Board asked the Trust to provide details of action taken and an assessment of the arrangements for the care and protection of children.

Cherry Lodge was not on the Board's risk register but was on Homefirst Trust's risk register from September 2006. There was no evidence that any untoward incidents associated directly with any service delivery problems at Cherry Lodge were reviewed by the Board or that it was examining the Trust's action plans to address the difficulties at Cherry Lodge. Evidence was not presented to indicate that the issues at Cherry Lodge were discussed as part of the contract review process.

The Board's response to us about monitoring of the service at Cherry Lodge from 1 August 2005 - 1 August 2006 suggested the Board believed that the responsibility for the regular direct monitoring of registered children's services had passed entirely to RQIA as the Board no longer received inspection reports. This indicated a lack of clear understanding of the different responsibilities of the RQIA, the Board and the Trust.

As the organisation with the overall responsibility for commissioning services to meet the needs of the local population, the Board should have sought an annual report about the service from Homefirst Trust. This was particularly important as the Board was not involved in reviewing the service level agreement between Barnardo's and Homefirst Trust.

Homefirst Trust

Accountability for professional decision-making and actions requires strong, confident, competent leadership and management in children services. Managers at each level create the ethos and culture of the organisation. They are responsible for ensuring that professional standards are met. So they must provide the processes to assist staff to provide services which meet expectations.

Best practice must be at the heart of children's services. Standards must be implemented, audited and reviewed by organisations in individual disciplines and across all disciplines, in line with the quality standard of corporate leadership and accountability.

What we found

The Trust's CC03/02 corporate parenting reports should have identified the important issues requiring action in the 2005-2006 discharge of statutory functions report. However the corporate parenting reports made no reference to children with a disability or of the need to plan for providing additional services for this group. This was despite the increase in referrals from 178 in 2004-2005 to 374 in 2005-2006.

At 31 March 2006, the Homefirst Trust's Children with Disability Team was dealing with 463 children. The rate per 10,000 children aged under 18, based on the 2001 census figures, had more than doubled. This clearly made providing services a major challenge.

The Trust's delegation of statutory functions report for 1 April 2005 - 31 March 2006 stated that:

> "pressures seemed to continue throughout the year for respite care for both children and adults."

It added that the transition from children to adult services for those with a learning disability continued to "cause problems in resource terms".

Daytime support services in the learning disability programme were, however, available to those young people making the transition to adult services.

Homefirst Trust Board was made aware that the Trust was not complying with all of its delegated legal functions through the CC03/02 reports of April 2005 - September 2005 and October 2005 - March 2006.

No evidence existed from the record of the Trust Board meeting of February 2006 of any requirement for remedial action to address these shortfalls. The Trust's Board minute recorded that the report was "approved by the Trust Board for onward transmission to the NHSSB".

How Homefirst Trust monitored quality

Homefirst Trust's 'Children Looked After' policy and procedures for placing children in residential units states, in section 11.8:

> "All children placed in residential units should have a named social worker who will visit regularly to see the child and discuss progress with the child and the residential staff. Such visits should be no less than once in the first week of placement and monthly thereafter."

In Homefirst Trust, the executive director of social work has the lead role for child protection and disability services and for reporting on how the Trust complies with the legal duties expected of it.

What we found

There are no stipulated requirements for visiting children who are receiving respite but not in continuous residential care. The DHSSPS has confirmed to RQIA that The Children's Homes Regulations (NI) 2005[46] do not specify visiting arrangements to individual children in respite care. Monthly visits, however, are viewed as "expected practice and an essential safeguard for Looked After Children in continuous residential care." (See Appendix 15).

Our audit of six case files provided evidence that children had not been visited in line with what is widely considered to be good practice for children receiving residential care, namely monthly visits. As referred to in Chapter 4, Homefirst Trust later informed the Review Panel that they did not apply the guidance for visiting children in residential care to the Cherry Lodge children, but visited under the Children (NI) Order 1995 Family Placements and Private Fostering Regulations and Guidance.[47] This provided for six monthly visits or "as circumstances require and when reasonably requested by the child or foster parent".

The Panel was concerned that less frequent visiting, although within legal requirements, coupled with the fact that no mention was made of children with a disability in the corporate parenting reports, could disadvantage these children with complex disabilities who were clearly "children in need" as defined in the Children Order. The Panel believed that children with a disability were equally deserving of the attention and corporate focus given to other children who were in residential care. The Panel considered that, given the vulnerability of these children when being accommodated, the Trust applied a different and distinct focus to the interpretation of

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[46] The Children's Homes Regulations can be accessed at:
http://www.opsi.gov.uk/sr/sr2005/20050176.htm

[47] The Children (Northern Ireland) Order 1995
The Children Order Regulations and Guidance consists of the following:
Volume 1: Court Orders and other Legal Issues
Volume 2: Family support, Childminding and Day Care
Volume 3: Family Placements and Private Fostering
Volume 4: Residential Care
Volume 5: Children with a Disability

its legal duties which, although within the law, meant that the needs of these children did not always receive as high a profile as Looked After Children.

Homefirst Trust's 2005-2006 annual discharge of statutory functions report to the Trust Board states that the: "governance arrangements within the Trust remained robust and risk registers were maintained in all Directorates".

We had concerns about how the Trust applied its LAC processes.

How the Trust applied its Looked After Children (LAC) processes

The report that the Trust submitted to us in October 2006 stated that it was best practice to apply Looked After Children processes to children who used respite in Cherry Lodge. We were concerned about a lack of clear guidance for Trust staff as applying LAC processes is a legal requirement, a point made clear by these pieces of legislation:

- The Children's Homes Regulations (Northern Ireland) 2005
- The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996[48]
- The Review of Children's Cases Regulations (Northern Ireland) 1996[49]
- The Children (NI) Order 1995 Regulations and Guidance Volume 4, Residential Care
- The Children (NI) Order 1995 Regulations and Guidance Volume 5, Children with a Disability

Under the provisions of The Children (Northern Ireland) Order 1995, Part IV, children are "looked after" by an Authority if they are accommodated for a continuous period of more than twenty four hours.

The Review of Children's Cases Regulations (Northern Ireland) 1996, clarifies the arrangements for reviewing children who receive respite or "short breaks". Regulation 11 states that each case must be reviewed within three months of the beginning of the first of the short periods and then at six monthly intervals.

The Panel believed that the Looked After Children regulations and processes provide the required protection for children with disabilities when they are accommodated for respite. As consistent with Article 23 of the UN Convention on the Rights of the Child, the application of LAC processes can complement and not undermine parental rights and responsibilities.

[48] The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996 can be accessed at: http://www.opsi.gov.uk/sr/sr1996/Nisr_19960453_en_1.htm

[49] The Review of Children's Cases Regulations (Northern Ireland) 1996 can be accessed at: http://www.opsi.gov.uk/sr/sr1996/Nisr_19960461_en_1.htm

What we found

We audited file records of the social workers who provided a service to the eight children.

There was no evidence of senior management in Homefirst Trust sampling or auditing LAC case records routinely before our review, to satisfy themselves about decision-making or to monitor the quality of social work practice.

This was concerning in view of those children who had received respite for some years and whose care plan for behaviour management required to be reviewed at regular intervals to establish whether Cherry Lodge could continue to meet their needs adequately and safely.

Information provided to us by Homefirst Trust about how it monitored the quality of service

We examined how Homefirst Trust monitored and supervised its compliance with its legal duties against the quality standard of corporate leadership and accountability.

Central to how the Trust managed its affairs and operated, is the supervisory work of senior managers, who monitored, advised and guided the work of social work staff. The Trust should have had in place effective systems to discharge, monitor and report on its responsibilities in relation to legal duties delegated to it, and in relation to working with other agencies.

What we found

Although Homefirst Trust has informed the Panel that senior staff were very familiar with the needs of these children and were regularly involved in discussions about their care, there was no evidence of this in the files or that any of the eight case files were audited by the senior social worker or any other manager.

There was only one file with a reference that the social worker had discussed the case in supervision. There was evidence in a number of files, however, that the social worker had contacted the senior social worker about permission for funding travel arrangements or additional respite care in response to pressures in the family.

Homefirst Trust's 27 October 2006 report on monitoring LAC review processes

This report was made available to us by the chief executive of Homefirst Trust, who indicated that LAC reviews provided the opportunity for senior staff to monitor social work performance. However, as is indicated in this report, review processes did not comply with Children Order requirements.

There was no evidence on any records to indicate that the Trust's independent reviewing officer had carried out quality assurance, as would be expected, of the LAC review process.

The 27 October 2006 report confirmed that the LAC file held by the children's disability team contained either a child-in-need assessment (Fam 3) or a comprehensive assessment of need. The report indicated that all necessary Looked After Children information was in place in Cherry Lodge in line with the Children (NI) Order 1995.

What we found

We did not find the evidence to verify this statement in the fieldwork and the residential files that we examined.

The chief executive confirmed that all children using Cherry Lodge had been reviewed on a six-monthly basis and that the reviews were up to date.

Our findings did not corroborate this statement. Our findings indicated that reviews had not taken place within legally and prescribed timelines.

Homefirst Trust's policy also stated that:

> "....the requirement that each person should be valued as an individual and their views, attitudes and opinions should be respected.
> 1) "User consultation is implicit in every stage of the work: assessment, service delivery and review.
> 2) "Consumer feedback will be obtained on one occasion during the year by questionnaire."

There was no evidence in either the residential or the fieldwork files for the eight children that any young person had been invited to attend their review, or that a written contribution by the parents or young people had been tabled for a review. Children's meetings or group work did not feature as standard practice in Cherry Lodge. Homefirst Trust did not raise this with Barnardo's. The research described in Appendix 16 indicates that listening to children with disabilities is not always carried out as a matter of routine. It is clearly an expectation in the UN Convention of the Rights of the Child[50] and was highlighted as something that could be improved in Equal Lives[51], the learning disability report from The Bamford Review of Mental Health and Learning Disability Services (Northern Ireland).

Members of the Review Panel acknowledged that there are particular challenges in gaining the views of children who have severe learning disabilities and who may have communication difficulties. To gain some indication of the preferences and choices of a child or young person, it may be necessary to use:

- the assistance of appropriately trained staff;

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[50] The UNCRC can be accessed at: http://www.ohchr.org/english/law/crc.htm

[51] Equal Lives: Review of Policy and Services For People with a Learning Disability in Northern Ireland, Review of Mental Health and Learning Disability (Northern Ireland), September 2005
It can be assessed at: http://www.mhldni.gov.uk

- augmentative communication systems, such as Makaton or electronic communication aids; or
- both of these.

A recent study from the University of York[52] may be of help in assisting organisations to support children with disabilities in making decisions. The study describes the need for staff training in this area and a recognition that this work is time-consuming.

The people who use services and their carers must be involved in how services are provided. The Panel was concerned with the lack of evidence of such involvement in all aspects of practice in both Homefirst Trust and Barnardo's with respect to these children's rights under Articles 12 and 23 of the UN Convention of the Rights of the Child.

Our view was that Homefirst Trust did not adhere to its own specification for LAC reviews and no evidence was presented to us that the Trust monitored or carried out quality assurance on the practices for consulting children.

Corporate processes

Homefirst Trust's report to the Panel on 27 October 2006, stipulated that corporate processes such as the complaints procedure, contract monitoring procedures, and whistle-blowing policy afforded opportunities for the Trust to be reassured about the services it provided and alerted to problems and concerns.

In light of the many concerns emerging from this review, we would question the robustness and effectiveness of such procedures and processes.

Barnardo's monthly and annual monitoring reports to Homefirst Trust

The Trust received monthly and annual monitoring reports from Barnardo's. Homefirst Trust's chief executive indicated these reports:

> "did not give the Trust cause for concern in respect of shortfalls in standards and practice".

Despite this, Homefirst Trust acknowledged reference to:

> "relationship problems within the staff team" in Barnardo's monitoring report and: "the potential to have impact on the standard and quality of care being delivered to children and young people."

The Barnardo's monitoring report also mentioned the suspension of three members of staff pending disciplinary hearings and the relationship problems between staff during October 2005. The Trust, as well as Barnardo's, had a duty to ensure that all staff were registered and appropriately reported to NISCC.

[52] Supporting the Participation of Disabled Children and Young People in Decision Making, Social Policy Research Unit, University of York, January 2007

What we found

In reviewing Homefirst Trust records we concluded that this information was accepted at face value and there was no further formal investigation by the Trust, although managers in Homefirst Trust were regularly seeking assurance via e-mail from Barnardo's directors.

Staff training

The Barnardo's monitoring report stated that training of Barnardo's staff was conducted by Homefirst Trust community nurses. A community nurse signed each staff member's record to show what training was done, and each member of staff signed that they regarded themselves as competent. This training related to nursing needs specific to children and covered areas such as:

- Paraldehyde training for one child (nine staff)
- BI-PAP training for one child (eight staff)
- Promed Elk hoist, Silvalea Hi-Easy Sling (eight staff)
- Digital rectal evacuation (DIRE) (two staff)
- Paediatric life support and emergency tracheostomy management (two staff)
- Epilepsy awareness and administration of rectal Diazepam (four staff)

What we found

This training appeared to be carried out over one day. The Panel believed that this amount of training was not adequate for using procedures in practice. This would require trainees to learn the topic, observe and practice under supervision. The trainer should also sign that the trainee could competently carry out the procedure. The peer reviewer did not observe this.

Monitoring the quality of the service level agreement

The service and budget agreement between Barnardo's and Homefirst Trust contained sections for writing about important quality areas which Homefirst Trust should have monitored. This reporting mechanism did not specify the quality of service to be provided or how the various aspects of the agreement would be monitored. This meant the Trust missed an opportunity to monitor how the service was being delivered and whether it was providing safe and effective care and meeting children's needs.

The Trust did make significant efforts to get clarity from Barnardo's about the position in relation to staffing and whether or not Barnardo's would be able to fulfil its obligations to the Trust. The Trust provided the Panel with copies of seven e-mails sent between March and May 2006 from the Trust to Barnardo's seeking clarification about the position.

The six-monthly monitoring reports and annual service level agreement report of 10 February 2006 focused primarily on reporting financial issues. It indicated that the Trust and Barnardo's would discuss the waiting list and review numbers of children receiving the service on 15 September 2006, at a further six-month review.

When we reviewed the key quality areas in the service and budget agreement with Barnardo's, we highlighted concerns in:

- Compliance with Protection of Children and Vulnerable Adults Procedures (POCVA) for all staff ;
- Staffing structures and ratios;
- Response to reporting incidents;
- Systems for assuring quality.

POCVA checks

The report stated:

> "All potential staff, employees or volunteers working within a scheme which caters wholly or partially for young persons under the age of 16 years or persons with learning disabilities must undergo a criminal records check. The Service Provider will carry out this procedure and should not employ individuals who appear unsuitable for this scheme. Failure to undertake police checks or act on information revealed in them may lead to a withdrawal of support for the scheme."

We questioned the reference to 16 years of age as The Children Order defines a child as a person "under the age of 18". Absent from this section of the document was any reference to the Northern Ireland Social Care Council requirement to comply with the Codes of Practice[53] or any indication about how the Trust would assure themselves of Barnardo's recruitment procedures to ensure the welfare, safety and protection of this vulnerable client group.

Staffing structures and ratios

The Trust reported that they required:

> "appropriate staffing levels are maintained at all times" and that "services associated with the scheme are provided by suitably trained staff who have an acceptable level of expertise and that an adequate skill mix is maintained".

We noticed that expectations were not specific, which could have contributed to the Trust's inaction at the time of the staff suspensions. Within this context, it was significant to note that during the period under review, many staff were either employed on a relief basis or on a temporary contract.

It would have been expected that the Trust would have reviewed information about Cherry Lodge staffing, compared this to what they would have expected of staffing in statutory units and commented to Barnardo's accordingly. RQIA should also have commented on such matters as part of the inspection and monitoring process.

[53] Codes of Practice for Social Care Workers and Employers of Social Care Workers, Northern Ireland Social Care Council, September 2002

Response to incident reporting

The Trust stipulated that:

> "The Service Provider will have in operation clear procedures for dealing with untoward events. These procedures should comply with the Trust document 'Notification of serious accidents and untoward events'. Where the Service Provider identifies an incident which in their view requires onward reporting to the Trust, the event should be reported to the Chief Executive's office no later than one working day after the event."

It was clear from the audit of residential and fieldwork files that Barnardo's did not comply with this aspect of the service agreement and, in the absence of thorough monitoring arrangements, this was not identified by the Trust.
We further noted that the Trust did not indicate how they responded to incidents when notified by Barnardo's. We could not find evidence of the reports stipulated by the Trust in the eight fieldwork files we audited. The Trust did not explain to the Panel where these records were kept or offer them to the Panel for information.

Systems for assuring quality

According to the service level agreement with Barnardo's, Homefirst Trust stipulated that:

> "The Service Provider will continue to have in operation a quality assurance system consistent with standards determined and approved by the Trust. The service to be provided should have clearly stated objectives and measurable outcomes. A copy must be submitted to the Trust."

We noted that Homefirst Trust was not specific about what it expected of quality assurance or of its own role in assuring quality in its own systems.

What we recommend as points for action and self-assessment

- The NHSSB should ensure it fulfils the duty of quality it has for any contracted services it commissions by setting up appropriate feedback arrangements with the Trust and the provider of the service to ensure action is taken appropriately following the receipt of reports of incidents.

- The NHSSB and Homefirst Trust should review the reporting and recording of risk management, by agreeing actions in response to risks identified.

- Homefirst Trust should audit files to ensure that:

  - LAC reviews are carried out and recorded on file;
  - the record is updated in terms of contact; and
  - steps are taken to enable young people to attend and contribute to their LAC review.

- Homefirst Trust should review how it complies with the Northern Ireland Social Care Council (NISCC) Code of Practice as this covers how it meets the duties of employers and employees. It should indicate what it finds to the Trust Board, who should agree any subsequent action that needs to be taken.

- Homefirst Trust should regularly review how it implements its supervision policy and take action to address problems identified. It should review how to provide evidence in case records that senior managers have reviewed cases and agreed care plans.

- The appropriate Homefirst Trust senior managers and directors should assure themselves about the adequacy and the appropriateness of training that the Trust offers other agencies, in terms of expected practice standards.
- Homefirst Trust Board should examine more closely the quality of information presented to it about its own performance reporting and about those with whom it contracts for a service. It should seek evidence of improvement plans being put in place and agree a clear arrangement for reporting back to the Board, within agreed timelines.

- For improvements to be lasting, Trust Board members should receive and agree a rigorous action plan put in place by Trust directors to address the issues highlighted in this report. The Executive Director of Social Work should prepare a report for the Trust Board on these actions and how they will be implemented.

- Homefirst Trust Board should ensure that Board members are fully aware of their responsibilities as corporate parents and of the information that Board members require in order to fulfil their responsibilities.

- Health and Social Services Boards and the new Health and Social Services Authority should ensure suitable arrangements are made with providers with whom it contracts to receive copies of:

  - audits undertaken by trusts and providers of services;
  - RQIA inspection reports; and
  - copies of each provider's annual quality report.

Chapter 8: Our conclusions

The focus of this review was on one small respite unit for children with complex disabilities. It offered an invaluable service to many families over the years and was highly regarded by parents and professionals alike. Nevertheless a serious untoward incident occurred one weekend which resulted in our review and this has exposed weaknesses in many procedures and systems. It has highlighted deficits in the accountability and management arrangements for monitoring, auditing and quality assurance of the service by all agencies.

Our detailed review has brought into the open evidence that some front-line staff themselves were very concerned about deteriorating standards of practice at Cherry Lodge. Although good systems and structures were in place for monitoring quality, external managers and other stakeholders, including RQIA, did not ask enough searching questions about the quality of care. An important learning point from this review is that all agencies must continuously and vigorously challenge the routine information they receive and not always take it at face value.

It appeared that all staff and agencies involved in delivering respite at Cherry Lodge were doing their best to provide a service that families found invaluable and children enjoyed. However, the incremental expansion from the original service to a seven-day residential facility was, with hindsight, not managed or monitored in a way that protected the children. Added to this incremental shift were acute staff relationship problems, a loss of experienced staff and an increase in the use of temporary and relief staff. Management responses focussed on the continued delivery rather than spending time and consideration on the potential build-up of risks to some very vulnerable children with complex needs. With the benefit of hindsight, it has become clear that more fundamental questions needed to be asked about the quality of the service in the early months of 2006.

It cannot be stated that the failings in this one small service are replicated across Northern Ireland. However, the learning for all agencies is that in-depth auditing of samples of direct front-line practice is an essential quality assurance tool, especially where there are staffing relationship problems.

The immediate responses by front-line staff to a serious incident of bruising have demonstrated the vital importance of frequent up-dated training on policies and procedures for child and vulnerable adult protection. We also recommend that all agencies review the arrangements they have in place for joint investigations which can be sensitive to the needs of children and young people with disabilities. Given the appropriate time, advocacy and imaginative methods of communication, more young people could convey to investigators what has happened to them. Consideration should be given to the inclusion of specific guidance in the Regional Policies and Procedures for Child Protection in Northern Ireland[54] about good practice in carrying out joint investigations for children with disabilities.

[54] Area Child Protection Committees' Regional Policy and Procedures, Northern Ireland, 2005. The ACPC Regional Policy and Procedures can be accessed at: http://www.childrensservicesni.co.uk

If an investigation into allegations of abuse is inconclusive, the responsibility weighs heavily on the employer of relevant staff and the provider of the service to make sure they continuously monitor any risks and have effective whistle-blowing procedures in place. These arrangements need to be shared with the families who use the service.

The review did not find evidence that Articles 2, 12 and 23 of the UN Convention[55] were being complied with or that the agencies heard or fully respected the rights of the children and young people. Even our Panel, because of circumstances, were unable to listen to the views of all the children. Some of the children and young people in Cherry Lodge were able to express their views but were not offered any access to independent advocacy: that is, to someone who could help them speak up. We think that this kind or arrangement would have helped the agencies to listen to the children's views. A greater focus is needed on children and young people's rights. These should always be at the heart of any children's service that trusts and independent agencies provide.

It was evident from our meeting with parents that families have little idea of the role, purpose and function of the different organisations who provide a service to disabled children. Clearer information should be provided to families to ensure that they and their children know who is responsible for doing what. To that end we have drawn up a chart of organisations and their respective responsibilities. An updated chart of the new structure would now be helpful for all parents. Parents also need to be clear about the legal requirements for authorities when they provide respite residential care to their children.

More consultation by RQIA would have given parents and children an opportunity to better understand its role as regulator. This would also have provided a route for concerns and complaints to be raised promptly.

We suggest that RQIA should, over the next three years, consider reviewing how well the policies, procedures and systems are functioning for respite services for children with a disability. RQIA should set a timetable for this review. It should focus on:

- how RQIA consults the various organisations and people concerned in its affairs (its stakeholders);
- the quality of care provided to children with a disability;
- what child protection policies and procedures are in place;
- the skill mix of staff; and
- staff training.

The review should also consider the appropriateness of all units' registration status, to ensure that social and health care for children and young people with complex needs is safe and effective.

The NHSSB has a quality and modernisation framework that is concerned with improving the services the board provides. As part of this, the Board should target specific areas of the services it contracts to other agencies such as residential

[55] The UNCRC can be accessed at: http://www.ohchr.org/english/law/crc.htm

services for children with a disability. The Board should monitor how these services are running against the standards set for Looked After Children. The aim should be to make sure that measures taken to intend to improve services have actually happened.

Not all the children admitted to Cherry Lodge were formally Looked After. Nevertheless most of them had very complex needs. Therefore, the discipline of multi-agency assessment, review, care planning and placement planning is essential to ensure their safe and effective care during respite. It is vital that there is communication between the field social workers, the community health staff, the education staff, the families and the front-line residential staff. Looked After Children guidelines provide the framework for such arrangements. If these arrangements are not in place for children with disabilities, their welfare can be jeopardised.

Barnardo's (UK) should take appropriate management action in response to the very worrying circumstances and issues that our review identified. The most important finding is that there was, and clearly still is, strong disagreement at different levels of the Barnardo's organisation. This is about whether the training, supervision and monitoring systems were in place; and about whether these were effective in producing the required results or helped to scrutinise the frontline delivery of safe and effective care.

Barnardo's also has a serious and continuing issue of staff mistrust that it needs to review. We found continuing acrimony among the staff team with a number of staff members seeking to have their perception of the truth confirmed. The close-knit nature of this staff team and the fact that they cannot help but see each other outside work, makes dealing with the mistrust even more difficult. The Cherry Lodge staff and all parents may require support to come to terms with the fact that the truth about the incident may never be known. Barnardo's will need to remain aware of the potential impact of this on the service and will no doubt, as an employer, wish to carry out its own investigation and plan of action.

We cannot state with certainty that an earlier Barnardo's management review would have prevented the June 2006 incident. What is very clear, however, is that the response to the incident would have been much more disciplined and better managed if all the agencies involved had better practices in place for supervision, management and recording practices and for implementing policy and procedures.

Since we carried out our review, and while compiling the report, we learned that Cherry Lodge temporarily ceased operating in January 2007 because of concerns about the adequacy of staffing levels needed to offer safe and effective care. The worst outcome for a child and family would be for the service to disappear. We welcome the fact that the Board and Trust are making a concerted effort and commitment to restore a quality respite service for the children and their families in this area, as they have a right to expect and deserve no less.

Acknowledgements

Given the timescales, the volume of documentary and verbal evidence received from relevant organisations, RQIA would wish to acknowledge all staff in those organisations whose work enabled this report to be completed.

Chapter 9: Summary of recommendations

Although these recommendations related initially to the organisations that were reviewed, the Panel formed the view that our recommendations would apply more generally to commissioning, designing, delivering and monitoring of any quality respite care service for children with disabilities. We recommend that all organisations should undertake a self-assessment using the action points set out at the end of each chapter of this report. We divided our recommendations into those that need to be addressed immediately (Priority 1) and those that should be addressed in the short to medium term (Priority 2).

Priority 1 Recommendations

1. When selecting respite facilities to meet the needs of children with disabilities, decision-makers must ensure that comprehensive multi-disciplinary assessments, care plans and reviews are in place. Decisions must include a careful consideration of whether or not the child's needs can be properly met by the particular service and any risks posed by or to other users of the service. The UNOCINI[56] form is considered to be an appropriate format to achieve this.

2. The Department of Health, Social Services and Public Safety (DHSSPS) should clarify guidance for social work staff about when to apply Looked After Children Standards for disabled children receiving respite care and who are accommodated.

3. The DHSSPS should review the current draft Care Standards to ensure that they reflect the requirements and current thinking about meeting the needs of children with disabilities. This is particularly important when considering the management of challenging behaviour in children with disabilities. The care standards should require compliance with Articles 2, 12 and 23 of the UN Convention on the Rights of the Child[57].

4. Trusts and Boards should ensure that corporate parenting reports and other overview processes are inclusive of children with disabilities when accommodated. Executive and non executive directors of Trusts and Boards should be clear about their responsibilities for children with disabilities when considering corporate parenting reports.

5. Organisations commissioning and providing services for children with disabilities must ensure that all staff receive frequent, up-dated training in child protection and, where appropriate, vulnerable adult procedures. Attendance at training sessions and regular updates should be mandatory with systems in place to monitor attendance. Implementation of child protection procedures should be audited. Child protection committees should review protection procedures and investigations to ensure that they can be sensitive to the

[56] UNOCINI - Understanding the Needs of Children in Northern Ireland, Pilot Multi-Agency Assessment Framework, DHSSPS, 2006

[57] The UNCRC can be accessed at: http://www.ohchr.org/english/law/crc.htm

needs of children and young people with disabilities. The recommendations in Our Children and Young People - Our Shared Responsibility[58] should be viewed alongside this report as many of the recommendations in Our Children and Young People - Our Shared Responsibility were complementary.

6. Organisations providing services for children with disabilities must ensure that appropriate policies, procedures and training programmes are in place to enable staff to meet the needs of the children receiving the service. This is likely to include:

    - Administration of medicines.
    - Managing invasive procedures e.g. tube feeding.
    - Managing challenging behaviour.

    Front-line practices should be subject to audit.

7. Barnardo's and Homefirst Trust must undertake risk assessments, support and supervision plans for all staff who were on duty during the weekend of 23 – 25 June 2006 and assurance should be given to the families who have used and hope to use Cherry Lodge in the future.

8. RQIA should consider reviewing how well their policies, procedures and systems are functioning for respite services for children with a disability.

Priority 2 Recommendations

1. Organisations commissioning or providing services for children with disabilities must ensure that every effort is made to obtain the views of young people and their families as part of the assessment, care planning and review processes. This may involve the use of independent advocates and alternative or augmentative communication systems.

2. Trusts should audit how social work practice complies with legal requirements for Looked After Children and the Northern Ireland Social Care Council Code of Practice for Employers of Social Care Workers. They should also ensure that the NI Social Care Council Code of Practice for Social Care Workers[59] is integrated into practice and incorporated in performance management and disciplinary systems. They should pay particular attention to staff working with children with disabilities when they are accommodated.

3. Trusts should examine how best to ensure multi-disciplinary input to the Looked After Children and other review processes for children with disabilities.

[58] Our Children and Young People - Our Shared Responsibility, Inspection of Child Protection Services in Northern Ireland, Social Services Inspectorate, DHSSPS, December 2006

[59] Codes of Practice for Social Care Workers and Employers of Social Care Workers, Northern Ireland Social Care Council, September 2002

4. All organisations should review how information is used at all levels, from fieldwork to Board reports to influence quality and measure whether or not expected standards are being met.

5. RQIA should consider a case-tracking system to examine standards of care for individual children with disabilities and recommend service improvements.

6. RQIA should agree a Memorandum of Understanding with the five Trusts and the Strategic Health and Social Services Authority on how they share information from inspection reports, investigations and reviews.

7. All organisations providing services should ensure that they have in place an adequate and accessible whistleblowing policy that allows staff to raise concerns outside the normal line management systems.

8. All organisations providing services should have systems in place for identifying poor practices in staff teams and be prepared to swiftly implement management reviews following whistleblowing and develop action plans to remedy the position.

APPENDICES

Appendix 1: Relevant Articles from the United Nations Convention on the Rights of the Child

Article 2

States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 7

States Parties shall cooperate in the implementation of the present Protocol, including in the prevention of any activity contrary thereto and in the rehabilitation and social reintegration of persons who are victims of acts contrary thereto, including through technical cooperation and financial assistance. Such assistance and cooperation will be undertaken in consultation with the States Parties concerned and the relevant international organizations.

States Parties in a position to do so shall provide such assistance through existing multilateral, bilateral or other programmes or, inter alia, through a voluntary fund established in accordance with the rules of the General Assembly.

Article 12

'the child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child'

Article 23

Article 23 of the UNCRC which requires Public Authorities to ensure a 'disabled child has the right to special care, education and training to help him or her enjoy a full and decent life in dignity and achieve the greatest degree of self-reliance and social integration possible'. Breaching Article 23 in turn breaches Article 2 of the Convention.

The United Nations Convention on the Rights of the Child can be accessed at: http://www.ohchr.org/english/law/crc.htm

Appendix 2: Documents received and sources of information from Barnardo's

List of policies and procedures received by RQIA from Barnardo's:

Policy and procedures in respect of:

1 Rectal Diazepam.
2 Enteral Feeding.
3 Management of Oxygen Therapy.
4 Rectal Paraldehyde.
5 Insulin Control.
6 Suction and Tube Feeding.

Evidence of appraisals and supervision:

1 Annual monitoring report.
2 List of quarterly performance reviews.
3 Any accountability report forwarded to Barnardo's headquarters in London.
4 Overview report on Cherry Lodge for Theresa Nixon Director, RQIA.
5 Copy of any review of the implementation of the code of practice for employers of Social Care Workers.(NISCC).
6 Homefirst / Barnardo's weekly management meetings.
7 Independent review commissioned by RQIA regarding Cherry Lodge.
8 Copy of staff team meetings.
9 Copy of care and control policy.
10 Intimate care policy procedures.
11 Report of the formal investigation conducted by Barnardo's into staff relationship problems which led to the suspension of 3 staff.
12 Evidence of monitoring of implementation of child protection procedures.
13 Review of complaints and action taken by Barnardo's.
14 Barnardo's supervision policy.
15 Register of children admitted to the Unit.
16 The number of days each child availed of respite.

Appendix 3 : Documents received and sources of information from Homefirst Trust

1 An overview report from Homefirst Trust indicating the process used by the Trust to monitor and evaluate the quality of services provided by Homefirst Trust staff to children who required respite care at Cherry Lodge Respite Unit from the period 1 August 2005 - 1 August 2006.

2 Homefirst Trust's Annual Discharge of Statutory Functions Report for 2005/2006 and the record of the minutes of the Trust Board meeting following the presentation of this report.

3 Copy of the Trust CC03/02 report brought to the Trust Board for the period 1 August 2005 - 1 August 2006.

4 Copy of the Trust Corporate Risk Register report for the period 1 August 2005 - 1 August 2006.

5 Copy of Homefirst Trust's Service Level Agreement with Barnardo's for 1 August 2005 - 1 August 2006 period

6 Copy of the policy and procedure for admissions to Cherry Lodge Respite Unit used by Trust staff.

7 Record/minutes of Homefirst Trust's monitoring meetings with Barnardo's to review their Service Level Agreement and agreed action to be taken by the Trust or Boards as a result of these meetings.

8 Record of all social work visits to children who availed of respite during the period 1 August 2005 - 1 August 2006.

9 Information about other respite services accessed by the number of children who received respite in Cherry Lodge in the period 1 August 2005 - 1 August 2006 by frequency and type

10 Copy of Homefirst Trust LAC policies/procedures and any other procedure relating to children with a disability

11 Report brought to Homefirst Trust Board in respect of the Trust's monitoring of the implementation of the Code of Practice for Employers of Social Care Workers in the period 1 August 2005 - 1 August 2006.

12 Copies of audits or reviews carried out by the Trust regarding the standard of assessment, care planning, risk management and review of children placed by the Trust in Cherry Lodge in the period 1 August 2005 - 1 August 2006.

13 Copy of supervision policy.

Appendix 4: Documents received and sources of information from Northern Health and Social Services Board

1. NHSSB Quality and Moderation Framework, 2005/06
2. Service and Budget Agreement between NHSSB and Homefirst Community Trust, 01 April 2005 - 31 March 2008
3. NHSSB Service Specification: Specialist Children's Unit for Children with Learning Disability and Severely Challenging behaviour.
4. Minutes of the Board/Trust Social Work Directors Meeting, Friday 31 March 2006.
5. Minutes of the Board/Trust Social Work Directors Meeting, Wednesday 31 May 2006
6. Minutes of the Board/Trust Assistant Directors Meeting, Friday 6 September 2005
7. Minutes of the Board/Trust Assistant Directors Meeting, Friday 21 October 2006
8. Minutes of the Northern Area Child Protection Committee, Wednesday 15 March 2006
9. Minutes of the Northern Area Child Protection Committee, Wednesday 19 July 2006
10. Minutes of the Children's Programme of Care Team Meeting, Thursday 18 August 2005
11. Minutes of the Children's Programme of Care Team Meeting, Thursday 22 September 2005
12. Service Performance Monitoring Meeting, 21 September 2005
13. Service Performance Monitoring Meeting, 25 January 2006
14. NHSSB Board Analysis of Trust Delegated Statutory Functions Reports, 01 April 2005 to 31 March 2006
15. Northern Area Children and Young Peoples Committee First Annual Review 2005/06
16. Northern Childcare Partnership Third Annual Review of the Childcare Plan 2003/04 to 2005/06 (also second Childcare Plan 2003/04 to 2005/06)
17. Northern Area Child Protection Committee Annual Report, April 2004 to March 2005
18. NHSSB Trust Corporate Parenting Returns, 01 April 2005 to 30 September 2005
19. NHSSB Trust Corporate Parenting Returns, 01 October 2005 to 31 March 2006
20. NHSSB Children's Statistics Indicators, April to June 2006
21. Homefirst Annual Monitoring Report, Residential Care in Homefirst Trust, 01 April 2004 to 31 March 2005
22. Combined Homefirst/Causeway Adoption Panel Annual Report 01 April 2004 to 31 March 2005
23. Corporate Risk Register, 22 February 2006
24. Social Services Directorate Risk Register, 22 February 2006
25. NHSSB Needs Assessment Programme 2005/06
26. NHSSB Indepth Monitoring Programme 2005/06
27. Evaluation of Rainbow Lodge, June 2005

28. NHSSB Audit of Trust adherence to boards child care duty specification, July 2006
29. NHSSB Registration and inspection unit annual report 2004/05 for Children's homes
30. Letter from Homefirst Trust to ADSS (NHSSB) regarding Cherry lodge, 05 January 2006
31. Fax regarding Homefirst Trust to ADSS (NHSSB) Cherry lodge - Barnardos, 18 January 2006

Appendix 5: The Independent Review Panel

Jacquie Roberts, Chief Executive Care Commission, Scotland (Independent Chair)

Terry Beecham, Senior Inspector, Care Standards Inspectorate for Wales

Dr Sandi Hutton, Consultant Paediatrician, Foyle Trust

Jacqui McGarvey, Programme Manager, South and East Belfast Trust

Barney McNeany, Interim Commissioner and Chief Executive, Northern Ireland Commission for Children and Young People

Miriam Somerville, Director of Hospital and Community Learning Disability Services, North and West Belfast Trust

(The review was started before the re-organisation of Health and Social Care in Northern Ireland. Therefore the titles and organisations referred to above are those in existence in October 2006)

Panel members agreed with RQIA's proposal that **Jacquie Roberts** would chair and co-ordinate the review process. She would ensure independence from the organisations linked to the review and advise on any issues of conflict that might arise. She was also to comment on any aspects of regulatory practice based on her experience with inspection processes in Scotland.

The Panel agreed that **Dr Sandi Hutton** would offer specialist advice on relevant aspects of children's health care needs, based on her paediatric training and knowledge of working with children with complex needs. She would also comment on relevant child or adult protection issues that emerged from the review. Dr Hutton audited in detail eight fieldwork files and a sample of the residential files of the children placed by Homefirst Trust in Cherry Lodge.

Jacqui McGarvey used her expertise in social work at senior management level to consider care planning, risk management and child protection issues against good practice criteria. She reviewed communications between fieldwork and residential services. She also gave advice on governance issues based on a review of information submitted by Homefirst Trust and the NHSSB, particularly in the context of Homefirst's contract with Barnardo's. Ms McGarvey also audited in detail the Homefirst Trust fieldwork files of eight children with complex needs audited by Dr Hutton and the RQIA Inspector for Cherry Lodge.

Miriam Somerville has extensive knowledge of learning disability services. She considered how adequate and effective the NHSSB's and Homefirst Trust's systems were in planning, commissioning and monitoring the service from Barnardo's. She contributed knowledge and experience from managing a respite facility in the former North and West Belfast Healthcare Trust for children with a disability, and of Muckamore Abbey Hospital Services. She also analysed Homefirst Trust's Disability Resource Panel minutes from 1 August 2005 to 1 August 2006 and other documentation presented to that Panel.

Barney McNeany's role was to monitor that the rights and interests of the children were upheld. He also considered, in line with legal requirements under articles 2, 7, 12 and 23 of the UN Convention on the Rights of the Child, the adequacy and effectiveness of the services provided by the agencies linked to the incident.

Terry Beecham is a senior care inspector from the Care Standards Inspectorate for Wales. He was asked, as a peer reviewer from another regulatory authority, to review how RQIA monitored the effectiveness of the service provided by Cherry Lodge. He did this by reviewing inspection and other records available between 1 August 2005 and 1 August 2006.

The Panel's members agreed that their review would focus on the period 1 August 2005 to 1 August 2006, to review practice at Cherry Lodge against the terms of reference that had been agreed.

The Panel met formally on 27 October 2006, 16 November 2006, 29 November 2006, 25 April 2007, 24 May 2007 and 28 June 2007.

Appendix 6: Notes of Panel meeting with parents on 28 November 2006

Cherry Lodge Review
Meeting with Parents
Tuesday 28 November 2006 at 7.45pm

Panel:

(Chair)	Jacquie Roberts	CEO	Care Commission
	Dr Sandi Hutton	Paediatrician	Foyle Trust
	Terry Beecham	Senior Inspector	CSIW
	Jacqui McGarvey	Programme Manager	South & East Belfast Trust
	Miriam Somerville	Director Learning Disability Services	North & West Belfast Trust

Issues Raised

1 Parents felt it would be helpful to be informed of inspections.
2 Parents would like to know the care path, that is who is responsible for the different issues.
3 Parents would like assurance that staff has a balance of both qualifications and experience and would like this given in writing.
4 Parents would like staff to be trained for medical needs, and know that the needs are more diverse than just epilepsy and oxygen administration. Training and qualifications should include administration of all drugs.
5 Parents would like to know in writing the situation regarding senior management cover, and what arrangements are in place.
6 Parents would like details of staff employment arrangements.
7 Parents would like there to be a continuity of care.
8 One parent agreed to forward, to the Panel, a copy of the letter families received from Barnardo's informing them of the staff suspensions in 2005.
9 Parents would like to be informed if the three employees who were suspended are still being paid.
10 Parents would like care plans to be simplified.
11 Parents would like the Northern Board and the Trust to do more about the funding of the unit.
12 Parents agreed that there are no problems with social workers.
13 One Parent associated changes in care with changes in the staff.
14 One parent has other care for the child in a hospice as well as Cherry Lodge.
15 Parents would like assurance from RQIA, Barnardo's and Homefirst Trust on how the situation is being monitored.
16 Parents would like to have a copy of the final report.
17 Parents would like staff to know they are appreciated.
18 Parents would like improved conditions replicated in other care environments

Appendix 7: Statement of purpose and function of Cherry Lodge

BARNARDO'S (NORTHERN IRELAND)

CHERRY LODGE RESOURCE CENTRE

CHILDREN'S HOMES REGULATIONS

(NORTHERN IRELAND) 1996

SCHEDULE 1 PART 1

STATEMENT OF PARTICULARS (PURPOSE)

This statement is available to :

Divisional Management staff of Barnardo's (N.I)

The Children Services Managers

and all other staff within Barnardo's (N.I) Children First Service

The Children and Parents who use Cherry Loge.

All other people mentioned in The Children's Homes Regulations (Northern Ireland) 1996, Schedule 1, Part II

Cherry Lodge was established to offer short-term periods of care to children with complex disabilities.

It is part of Barnardo's (NI) Children First Service.

The objectives of Cherry Lodge are to:

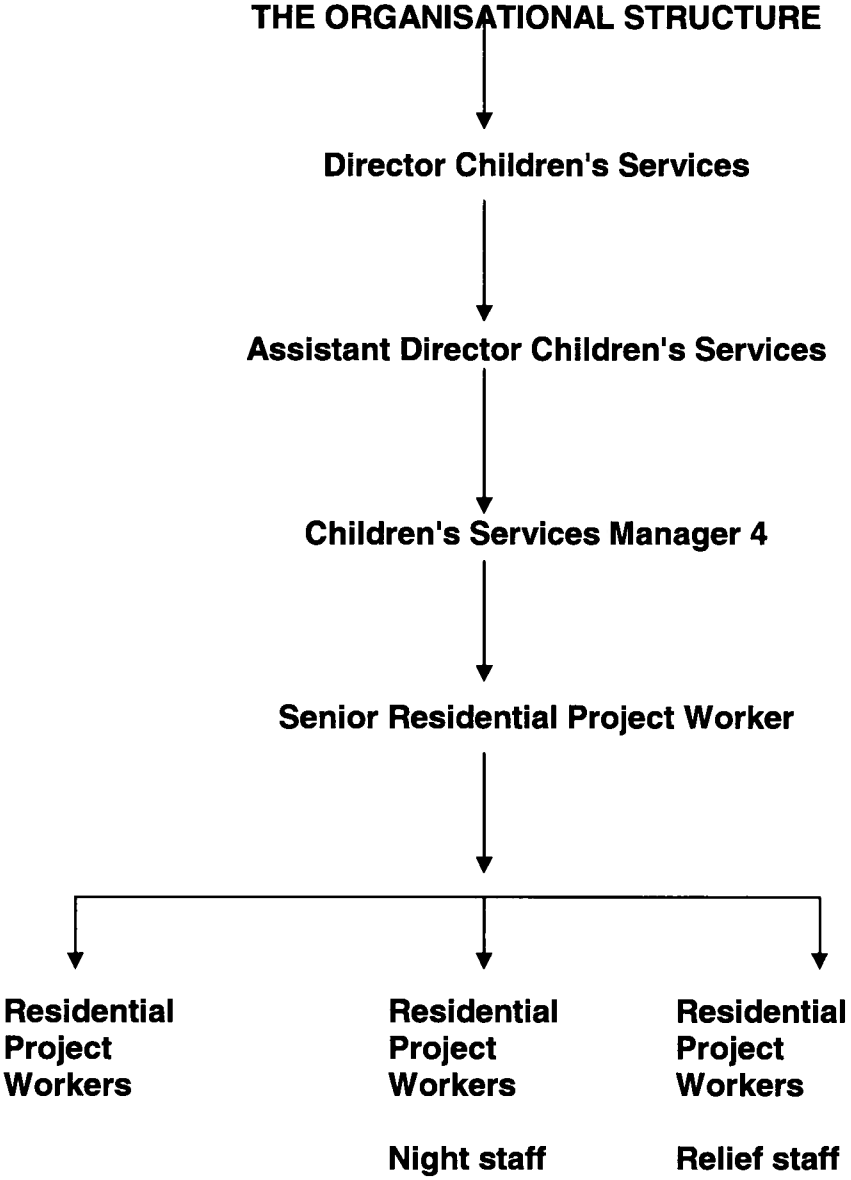
- Support the development of each child in placement.
- Support the family in their care of each child.

Cherry Lodge is part of Barnardo's Northern Ireland Division, whose headquarters is situated at 542-544 Upper Newtownards Road, Belfast BT4 3HE

Cherry Lodge offers care to children/young people:-

- Up to the age of 18 years.
- Of either sex.
- Limited to three residents at any given time.
- Who have a complex disability.

THE ORGANISATIONAL STRUCTURE



Experience and qualifications of staff can be obtained through Barnardo's.

Facilities and services

Facilities

Cherry Lodge has all of the amenities to be expected in a modern bungalow. It was purpose built, and is able to accommodate wheelchairs easily. There is good space inside the house with three bedrooms and two living rooms. It has two bathrooms which contain specialist equipment. There is a large, enclosed landscaped garden and soft play area to the rear with children's swings and facilities for a Sensory garden which was completed in Spring 2005. Special equipment to meet individual needs is available or can be purchased as required.

Safety is an important aspect throughout our work and this is evident in the fire alarm and associated equipment, in the arrangements for opening and securing the two front doors, and in the availability of such equipment as "baby listeners" etc.

Services

At any given time there are a minimum of two staff on duty when children are present in Cherry Lodge. This ratio is increased when the assessed needs of the children indicate that it is necessary. At night there is a minimum of one waking night staff on duty, backed up by some-one on sleep-in duty.

Placements are planned individually and there is a strong emphasis on ensuring that any child's stay is enjoyable and stimulating. Individual and group activities are planned in advance, and, particularly in the warmer months, will include outdoor activities, trips etc.

Cherry Lodge acquired a project vehicle during the year 2002 this has been of great benefit to children and staff enabling wheelchair users to have increased opportunity and choice in a range of outings.

A snoozeelen room was completed March 2005. This has added to the range of activities for the children receiving the service.

The project works in partnership with children, parents and other professionals, so that the individual needs of children are met as fully as possible. If any child has a particular clinical, paramedical or psychological need, this is discussed with all those involved and suitable plans developed.

The planning and delivery of the service is reviewed regularly and the views of the child and parents are of paramount importance to this process.

Protection and promotion of children's health

Cherry Lodge offers short-term care only, and it is accepted that parents/carers carry the major responsibility in relation to the protection and promotion of each child's health.

Cherry Lodge's responsibilities include:

a) Monitoring each child's health and development during their stay, and giving clear reports to parents (always), and doctors and other professionals as required.
b) Taking appropriate action should a child become unwell or ill. This may include first aid procedures, or a referral to doctor, dentist or hospital. (An attempt will be made to contact parents/carers if the child requires attention from a doctor, dentist or hospital).
c) Ensuring that all the relevant numbers of staff are properly trained to protect and promote each child's health e.g physiotherapy procedures, feeding techniques, first-aid training etc.
d) Implementing an appropriate policy in the control, administration and disposal of medications.
e) Contributing to family discussion, medical meeting, case discussions etc about the developing health care needs of each child.
f) Publicising and implementing Barnardo's Safeguarding and Protecting Policy.

Fire precautions and associated emergency procedures

All Barnardo's Projects operate within its Fire Safety Management Policy. This requires:

a) Maintenance plan to ensure the proper upkeep of systems, a record of which is available in Cherry Lodge.
b) Staff training plan to ensure that fire drills are practised, appropriate information is available to all staff, and a fire evacuation plan is in place. Records of these are kept within Cherry Lodge. A copy of the emergency fire routine is displayed in Cherry Lodge together with a floor plan.

Religious observance

Any special requirements e.g. diet will be observed when a child is staying in Cherry Lodge, and visits are welcome from Ministers, Priests, or any representative of the religious orders. Generally it will not be possible for staff to accompany children to religious services, but every effort will be made to come to an arrangement where each child can attend if this is required.

Arrangements for contact

Children come to Cherry Lodge for short stays only. Generally parents/carers are expected to arrange transport and as such parents/carers will be in Cherry Lodge at the beginning and end of each stay. This level of contact is essential to the development of good understanding, and it helps Cherry Lodge staff to offer a responsive service to each child. Whilst each child stays in Cherry Lodge contact from parents and family is welcome. Particularly in the early days of placement parents have found that it is reassuring to phone to hear how things are going.

Arrangements for education

Any child who is accommodated in Cherry Lodge should continue with their normal education. This could only be varied at the request/instruction of parents (or those with parental responsibilities) and only then in exceptional circumstances. Staff facilitate children to complete homework when required in appropriate setting.

Care and control policy

The project operates within Barnardo's Care and Control Policy which emphasises the need for positive control and identifies sanctions and methods of control which could be used. In particular it identifies methods of control forbidden by law as: corporal punishment; deprivation of food and drink; restrictions or refusal of visits/communications(as a punishment); requirement to wear distinctive or inappropriate clothes; use or withholding of medication or medical or dental treatment; use of accommodation to physically restrict the liberty of any child; intentional sleep deprivation, imposition of fines and intimate body searches.

Furthermore Barnardo's forbids the following: use of community /group disapproval, and threat of exclusion from the project. Within the Children First Service Project we advocate parental involvement in the design of care programmes, and the use on non-aversive behavioural intentions as a first choice. The Behavioural Management Policy works in conjunction with our Care and Control Policy. Parental involvement and consent is essential to the successful implementation of any behavioural programme. Aversive strategies will only be used as a last resort and to prevent harm to the child or others. It is recognised that it is sometimes necessary to restrain a child physically, but this will be done only to prevent them damaging themselves or others.

Unauthorised absences

If such an event occurred it would be viewed as a serious incident, and the project would notify parents, police and management immediately.

Representation/complaints procedure

Normally the queries and grumbles which are part of the daily interaction are sorted through good practice. However if a more fundamental problem is perceived by the user that cannot be resolved this way, he/she has the right to decide whether or not to pursue the issue by using the complaints procedure, which has three stages:

a) The informal/problem-resolving stage

At this stage every effort is made to resolve the complainant's problem/complaint within the project, to his/her satisfaction without having to take the matter to the next stage. The complainant is offered the support of an advocate/representative to help him/her to get the matter resolved.

b) Formal stage 1

This is the next stage which the complainant may decide to use, if the matter has not been resolved to their satisfaction at the problem resolving stage. The complaint is registered with the Complaints Co-ordinator, who, together with the Divisional Director will appoint an Investigating Officer from within Barnardo's, usually someone at Assistant Divisional Director level, and an Independent Person, this is someone who is completely independent of Barnardo's. The Investigating Officer will interview everyone concerned and examine all relevant written records. They will then write a report with conclusions and recommendations. The Independent Person will determine who they wish to see and what material they want to examine. Their role is to form an independent view of the complaint and the way it has been dealt with under the procedure. They will also give their views in writing. When all written comments have been received, the Divisional Director will write the formal response to the complaint, which will be circulated to everyone concerned.

c) Formal stage 2

This is the final stage and comprises a review of the complaint and everything that has happened so far, by a Panel of three people, not previously involved in the complaint, one of whom will be an Independent Person, who is completely independent of Barnardo's. The complainant can ask for the matter to be considered by the Panel if he/she is not satisfied with the formal response made at Stage 1. The Panel will make their recommendations after reviewing all the written information and hearing from all those people involved in the complaint. Their recommendations are sent to the Director of Child Care who will write the Organisations formal response after consultation with the Independent Person from the Panel. The Director's decision is final.

Barnardo's produces a range of information in the form of leaflets and posters that are available for use in all projects and to give to consumers. In addition some projects will produce additional information into a project handbook. Everyone who receives a service from a Barnardo's project should be given a leaflet, which tells them about the complaints procedures and how to use it, when they first start receiving a service from the project. The procedure should also be explained to the consumer so that they understand how to use it.

Reviews

Each child accommodated within Cherry Lodge will be formally reviewed on a six-monthly basis. This alternates between a LAC and a Cherry Lodge review for all children receiving overnight care. Parents/Carers and children (when appropriate) will be invited and encouraged to attend reviews.

A formal review meeting is part of a continuous process of planning and reconsideration of the plan for the child. It should ensure the full participation of both children and parents, and offer a structured, co-ordinated approach to the short break care plan. The information gathered through the review can also be used to contribute to other, statutory, review and assessment processes.

Arrangements for consulting with a child or young person regarding the care plan

Staff in Cherry Lodge communicate carefully and imaginatively with each child concerning their care plan. Many children will not have formal communication, therefore judgements about preferences will be based on interpretations of each child's behaviour, reactions, non-verbal and sub-verbal cues. Also the advice and guidance of parents, carers, teachers and other relevant people will inform and influence methods of communication, and the design of individual care plans.

The arrangements for involving a child or young person in group care decisions

As explained in the previous paragraph every effort will be made to develop relevant methods of communication with each child.

Group activities and composition will be developed through the use of appropriate communication, the advice and guidance of those who know the child best, and careful observation.

Appendix 8: Research literature about national and local respite services

The Mencap survey, Breaking Point Families Still Need A Break, 2006[60], indicates that:

- Seven out of 10 families have reached, or come close, to breaking point because of a lack of short break services
- Seven out of 10 families provide more than 15 hours of care every day
- Five out of 10 families provide care during the night
- Nine out of 10 family carers are in poor mental health and believe it is because of the amount of care they provide.

A Scottish Executive's report indicates that if families have access to short break services, they value them highly[61]: "Families reported they barely receive enough to meet their needs. While the number of services providing short term breaks has grown over recent years they are still not meeting demand."

This report states that: "the particular needs of children and young people with a learning disability often appear as a footnote in the initiatives that have emerged and are overshadowed by the numbers and needs of other groups."

The report also states that: "children and young people with a learning disability have not benefited as they should have done from initiatives to improve children's experiences, or from measures focused on learning disability issues."

The report notes: "the effort to get a short term break can be tiresome and this varies significantly across the country. While there is a shortfall in provision, it is difficult to work out how much."

Childcare services have improved overall since the government launched its childcare strategy for Northern Ireland, 'Children First', in 1999[62]. Since then a greater variety of support services has become available to families who have a child with a disability[63].

However, surveys in Northern Ireland[64] suggest:

- up to 70% of families who use short break services need more of this type of service;

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[60] Breaking Point - families still need a break, A report on the continuing problem of caring without a break for children and adults with severe and profound learning disabilities, MENCAP, September 2006

[61] The Same as You? A Review of Services for People with Learning Disabilities, Scottish Executive, 2006

[62] Children First - The Northern Ireland Childcare Strategy, DHSS, T&EA, DENI, September 1999

[63] Robinson

[64] Sines, D (1999) Identifying the need for respite care for people with learning disabilities in Northern Ireland. Journal of Learning Disabilities for Nursing, Health and Social Care, 3, 81-91; McConkey R and Adams L (2000) Matching short-break services for children with learning disabilities with family needs and preferences. Child: care, health and development, 26,429-444

- practical and emotional support to families tends to be fragmented and patchy; and
- children in this group receive less respite service, per head of population, than others.

A recent study by McConkey et al[65] in one geographical area of Northern Ireland confirmed that older children with learning disabilities, severe communication difficulties or challenging behaviours were more likely to become Looked After.

The study also indicated that the views of children and young people with a learning disability are not routinely sought. When they are, it emerges that they share similar hopes and fears with their non-disabled peers, but also have additional specific concerns including difficulty having friendships, experience of bullying, isolation and barriers to play and leisure opportunities.

A research survey carried out by McConkey and Adams (2000)[66] shows that short breaks or respite care are a much valued service by families and the demand is likely to exceed supply. It highlights the importance of providing services to meet the needs of children and families.

This research also shows:

- Families are having to put their names on waiting lists for short breaks and the short breaks that they are getting are not long enough.
- Children with complex health needs, challenging behaviour and disabilities such as autistic spectrum disorders, boys and youngsters from mixed race or minority ethnic communities, are less likely to have short breaks.

[65] McConkey R et al (2004) The Characteristics of Children with a Disability Looked After away from Home and their Future Service Needs. British Journal of Social Work, 34, No 4 (2004): 561-576
[66] McConkey R and Adams L (2000) Matching short-break services for children with learning disabilities with family needs and preferences. Child: care, health and development, 26,429-444

Appendix 9: The Review of Children's Cases Regulations (Northern Ireland) 1996

The Review of Children's Cases Regulations (Northern Ireland) 1996, sets out arrangements governing the manner in which the case of each Looked After Child should be reviewed and the considerations to which each responsible authority should have regard. Regulation 3 provides that each case is to be reviewed within two weeks, of the date upon which the child begins to be looked after or provided with accommodation by a responsible authority. Subsequent reviews shall be carried out not more than three months after the first and thereafter at intervals of not more than 6 months after the date of the previous review. The exception to this is Regulation 11, which allows for a series of short periods at the same place to be treated as a single placement, provided that no single period is to last for more than four weeks and the total duration of the periods is not to exceed 90 days, in any period of 12 months. If these conditions are met the case is to be reviewed within three months of the initial placement and not more than 6 monthly thereafter. This is further reinforced by Article 25 of the UN Convention which states "A child placed for care /protection or any treatment of physical/mental health has a right to periodic review.....and all other circumstances relevant to his/her placement."

The Regulations can be accessed at:
http://www.opsi.gov.uk/sr/sr1996/Nisr_19960461_en_1.htm

Appendix 10: Standards used to inspect management and administration of medicines

The standards used to inspect how medicines were managed and administered were as follows:

1The management of medicines should be in accordance with legislative requirements, professional standards and DHSSPS guidance.

2 The policy and procedures should cover each of the activities concerned with the management of medicines.

3 Staff who manage medicines should be trained and competent. A record should be kept of all medicines management training completed by staff.

4 When necessary, in exceptional circumstances, training in specific techniques (e.g. the administration of medicines using invasive procedures; the administration of medicines through a PEG-tube; the administration of medicines in treating a life-threatening emergency) should be provided for named staff by a qualified healthcare professional.

5 Medication errors and incidents should be reported, in accordance with procedures, to the appropriate authorities.

6 Practices for the management of medicines should be systematically audited to ensure they are consistent with the home's policy and procedures and action is taken when necessary.

7 Medicine records should be constructed and completed in such a manner as to ensure that there is a clear audit trail.

8 The following records should be maintained:

Personal medication record
Medicines administered
Medicines requested and received
Medicines transferred out of the home
Medicines disposed of.

9 The receipt, administration and disposal of all Schedule 2 controlled drugs should be recorded in a controlled drug register.

10 Any omission or refusal likely to have an effect on the child's health or wellbeing should be reported to the person with parental responsibility and/or the prescribing practitioner.

Appendix 11: Inspection proforma for Regulation 29 (1) incidents

Scope of the Inspection

The inspection focused on a number of identified key reports sent to:

1 Barnardo's
2 Homefirst Trust
3 Northern Health and Social Services Board
4 Regulation Quality Improvement Authority

Incident Record Inspection Standard Criteria

What should have been in place

1 A robust organised system for recording incidents
2 Evidence of a consistent approach by all staff in relation to the recording of incidents
3 Evidence of an agreed policy for recording incidents that is available to all staff
4 Evidence that all relevant staff had undertaken training in relation to the recording of incidents.
5 Evidence that all relevant staff are knowledgeable in relation to follow up action required following the occurrence of an incident
6 Evidence that there were risk assessment systems in place in order to prevent the re occurrence of incidents where possible
7 Evidence that Management took action as a result of incidents as they occurred

What was in place

1 For the purpose of this inspection all incidents had a written report

Quality of what was in place

For the purpose of this inspection the quality of the report was measured using the following criteria

1 Clear concise report
2 Accuracy of account
3 Follow up action plan
4 Reporting to management
5 Preventative action

Appendix 12: Copy of letter sent to parents of users of Cherry Lodge in December 2005

Dear xxx

I am writing to let you know that I have had cause to look in some detail at staff relationships within Cherry Lodge and have asked for our Personnel section in Belfast to help me with this.

Because of the potential that some issues may be serious in nature I have had to ask three members of staff not to come to work for the time being. This is entirely precautionary at this stage. I expect to be in a position to write to you again with a fuller account in January.

Meanwhile, let me reassure you that the highest standard of care we expect in Cherry Lodge will continue to be delivered.

I would like to take this opportunity to wish you and your family a Happy Christmas and a peaceful new year.

Yours sincerely

Assistant Director of Children's Services

Appendix 13: Northern Ireland Social Care Council - Codes of Practice for Social Care Workers and Employers of Social Care Workers (September 2002)

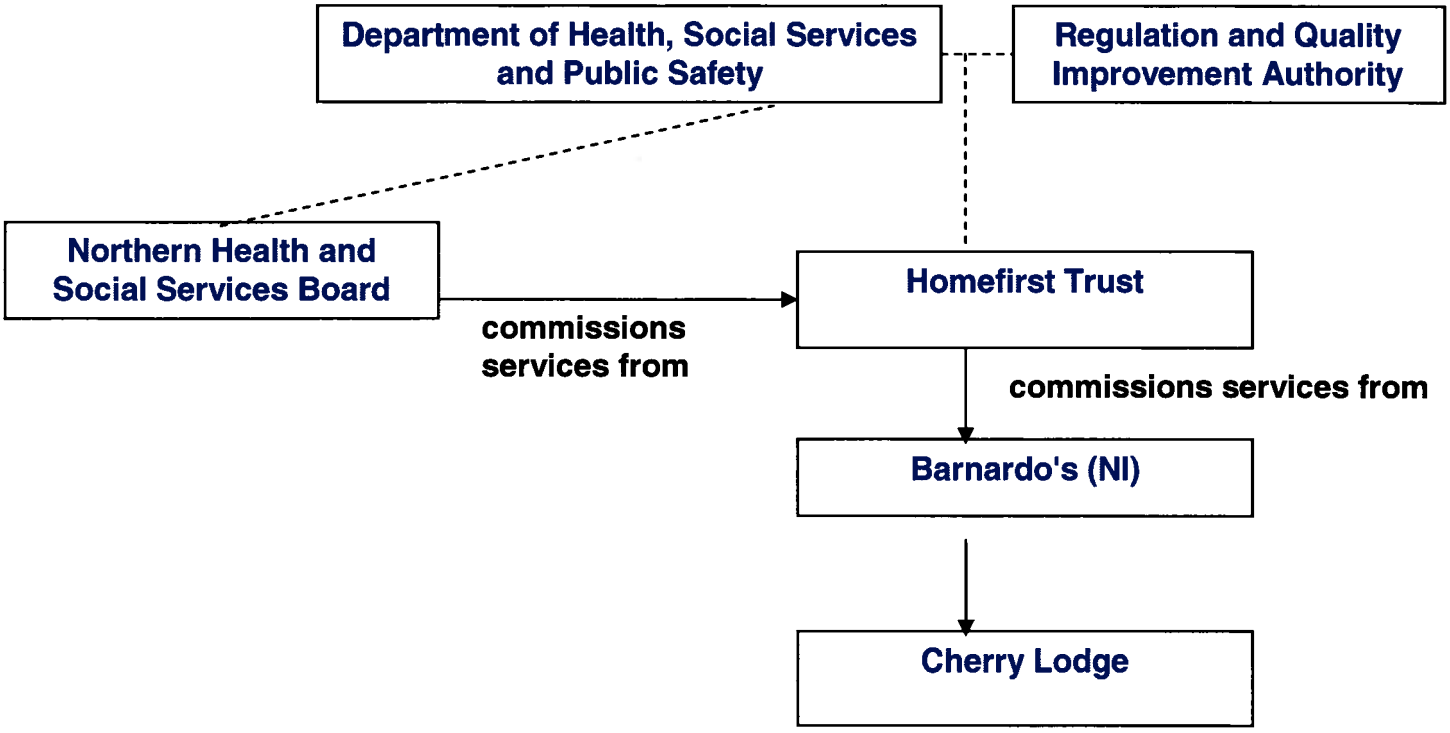
The Code of Practice for Social Care Workers is a list of statements that describe the standards of professional conduct and practice required of social care workers as they go about their daily work. The intention is to confirm the standards required in social care and ensure that workers know what standards of conduct employers, colleagues, service users carers and the public expect of them.

The Code of Practice for Employers of Social Care Workers sets down the responsibilities of employers in the regulation of social care workers. The Code requires that employers adhere to the standards set out in their code, support social care workers in meeting their code and take appropriate action when workers do not meet expected standards of conduct.

The codes are intended to reflect existing good practice and it is expected that workers and employers will recognise in the code the shared standards to which they already aspire.

The NISCC Codes of Practice can be accessed at:
http://www.niscc.info/registration/pdf/codes_of_practice.pdf

Appendix 14: Chart of organisations at the time of the review



Key:

- **Department of Health, Social Services and Public Safety (DHSSPS)**
  Responsible for establishing policy and law for health and social services in Northern Ireland

- **Regulation and Quality Improvement Authority (RQIA)**
  An independent body which monitors and inspects the availability and quality of health and social care services and encourages service improvement.

- **Northern Health and Social Services Board (NHSSB)**
  The Board assesses the health and social care needs of local people and plans, secures and pays for services from organisations and agencies such as Homefirst Trust.

- **Homefirst Trust**
  The Trust provides health and social services. It also secures and pays for services from other organisations, such as Barnardo's. (The Trust is now part of the Northern Health and Social Care Trust).

Appendix 15: Copy of text of letter dated 16 May 2007 from Chief Social Services Officer, DHSSPS to Chief Executive, RQIA

Dear Mrs Burnside

Thank you for your letter dated 9 May 2007 seeking clarification of regulatory requirements and statutory guidance in relation to visits to 'looked after' children. I have spoken to Hilary Harrison about the communication between herself, Niall Young of the Northern Health and Social Care Trust and Jacqui McGarvey, Peer Reviewer, RQIA. No meetings took place, but the following information was provided to Niall and Jacqui by telephone:

1. The Children's Homes Regulations (NI) 2005 require the registered provider to visit the home at least once a month [Regulation 32 (3)]. As you are aware this requirement relates to the registered provider's management and monitoring responsibilities which the regulations. The regulations do not, however, specify visiting arrangements in relation to each individual child looked after or accommodated in a children's home. Whilst Boards' and Trusts' own guidance and service level agreements may well stipulate the need for once monthly visits by social workers as a minimum standard, there is, strictly speaking, no current statutory requirement (i.e. no requirement in the Children (NI) Order or extant regulations) for a child in a residential children's home to be visited once a month by a social worker or other authorised person. Similarly, Volumes 4 and 5 of the Children Order Guidance and Regulations which respectively set out the arrangements for children in residential care and disabled children do not deal with this issue. It is, nevertheless, expected practice and an essential safeguard that looked after children who are in residential care as a continuous care placement should be visited at least once a month and more frequently, should the need arise;

2. By way of contrast, the Foster Placement (Children) Regulations (NI) require the responsible authority to 'make arrangements for a person authorised by it to visit the child in the home in which he is placed .... within one week from its beginning and thereafter at least once a month ...etc.' [Regulation 6]. However, Regulation 9 provides, in the case of a child placed in a series of short term placements in the same foster home, for these to be treated as one placement and the visiting arrangements to be reduced to once in the first 7 placement days and thereafter at intervals of not more than 6 months. The provisos are that no single placement can last more than four weeks and the total cannot last more than 90 days;

3. The Arrangements for Placement of Children (General) Regulations (NI) also provide that where a child is placed in a series of short term placements at the same place, these may (subject to the same provisos as outlined in point 2) be treated as a single placement [Regulation 13];

4. In the case of children receiving short breaks or respite care in a children's home, clearly the Arrangements for Placement of Children Regulations apply. In the absence of any stipulated requirements in respect of social

worker/authorised person visits, however, it would seem sensible to apply the same principles as those that have clearly informed the arrangements for short term placements in the fostering regulations. In other words the frequency of visits should not be rigidly set down at once a month regardless of the child's circumstances but should be determined by the assessed needs of the child and family. The care plan to address these needs should be agreed with the child, parents and the respite unit and should include the arrangements for social work visits and other professional involvement. The plan setting out the arrangements for the child's care should be reviewed in accordance with the Review of Children's Cases Regulations (NI) 1996; and

5. It is somewhat anomalous that the regulations governing children in residential care and those in foster care should not contain similar provisions in relation to the visiting of children by authorised persons. As this appears to be an issue which has been particularly highlighted by the Cherry Lodge inspection, the RQIA may wish to make an appropriate recommendation in its report or otherwise raise the matter formally with the Department.

This remains the Department's view.

I hope this is helpful to you. If you require any further clarification on these matters perhaps you would contact Dr Hilary Harrison (telephone 028 9052 0730) who will be happy to assist. I am copying this correspondence to Mr G Houston, Executive Director of Social Work, Northern Health and Social Care Trust and Dr M Briscoe, Director of the Safety, Quality and Standards Directorate.

Yours sincerely

PAUL MARTIN
Chief Social Services Officer

cc Mr F Bradley, Child Care Policy Directorate, DHSSPS

Appendix 16: Research about listening to children

Queen's University Belfast, undertook some research on behalf of the Northern Ireland Commissioner for Children and Young People (NICCY),[67] which indicated:

> "Northern Ireland does not listen to children and young people, or worse, it affords them only minimalist tokenistic opportunities to participate and engage with adults.....Not being heard, not being allowed to participate in decisions made about them and not being consulted about changes to their lives, big and small, is the single most important issue to children and young people in Northern Ireland."

Of particular note here, is the General Comment no. 9 2006 from the Committee on the Rights of the Child which notes that:

> "Children with disabilities are still experiencing serious difficulties and barriers in the full enjoyment of the rights enshrined in the Convention. The Committee emphasizes that the barrier is not the disability itself but it is a combination of social, cultural, attitudinal and physical barriers which children with disabilities encounter in their daily lives.
>
> "...attention should be paid to transforming existing institutions, with a focus on small residential care facilities, organised around the rights and needs of the child, to developing national standards for care in institutions and to establishing rigorous screening and monitoring procedures to ensure effective implementation of these standards"[68].

A recent study by McConkey et al[69] in one geographical area of Northern Ireland confirmed that older children with learning disabilities, severe communication difficulties or challenging behaviours were more likely to become Looked After.

This study also indicated that the views of children and young people with a learning disability are not routinely sought. When they are, it emerges that they share similar hopes and fears with their non-disabled peers, but also have additional specific concerns including difficulty having friendships, experience of bullying, isolation and barriers to play and leisure opportunities.

The Bamford Review of Mental Health and Disabilities concluded its work at the end of 2006. The needs of children with learning disabilities were considered in the learning disability report, Equal Lives. Although examples of good practice in respite care were presented to the Equal Lives Review[70], there was no evidence that such

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[67] Kilkelly, Kilpatrick, Lundy, Moore, Scraton, Davey, Dwyer & McAlister (2004): Children's Rights in Northern Ireland. Northern Ireland Commissioner for Children and Young People in association with Queens University, Belfast

[68] General Comment No. 9 (2006) The Rights of Children with Disabilities: Committee on the Rights of the Child

[69] McConkey et al (2004) The Characteristics of Children with a Disability Looked After away from Home and their Future Service Needs. British Journal of Social Work, 34, No 4 (2004): 561-576

[70] Equal Lives: Review of Policy and Services For People with a Learning Disability in Northern Ireland, Review of Mental Health and Learning Disability (Northern Ireland), September 2005

practice is consistent across Northern Ireland. Recurrent concerns presented to the Equal Lives Review included:

1 Respite is currently defined as placements, which are usually planned in advance, where a child moves out of the family home for a short break. Services are variable in Northern Ireland and parents frequently complained they could not get access to them, particularly in emergencies.
2 The need for additional support for children with an Autistic Spectrum Disorder, multiple disabilities, or both
3 There is an emerging need for more services after school and for older children.

The University of York, Social Policy Research Unit published research findings in January 2007 - Supporting the Participation of Disabled Children and Young People in Decision Making. This showed that the participation of disabled children at any level of decision making was only happening for a small number of children and often only for those who were most articulate and confident. The study shows that when children did participate they viewed it as a very positive experience but it must be recognised as being time consuming and staff need to be well trained.

A Practice Guide has been produced by Social Care Institute for Excellence (www.scie.org.uk) in February 2006. This is aimed at increasing the participation of children including those with disabilities.

Appendix 17: Glossary of abbreviations, organisations and terms

Appraisal:
An examination of people or the services they provide to judge their professional qualities, success or needs.

Audit:
In this report, an audit means a thorough review of the procedure used for diagnosing, caring for and treating children and young people, and helping them back into their homes and families. Carrying out an audit involves considering how funding is used, investigating the effect that care has on someone's quality of life, and making changes if necessary.

Barnardo's:
Barnardo's is a charity that provides services to vulnerable children and their families through projects at home, school and in local communities.

Care standards:
These set the standards that care practices, such as nursing homes and residential homes, are expected to meet. They are linked to quality standards, which are explained later in this glossary.

Cherry Lodge:
Cherry Lodge is a three-bed respite home in Randalstown, County Antrim. It was established by Barnardo's NI Division Children First Services to offer short-term care to children up to 18 years of age who have complex disabilities. Cherry Lodge also provides day care services.

Its objectives are to help each child or young person to develop and to help each family to care for their child.

The respite service provided by Barnardo's was commissioned by the Northern Health and Social Services Board and Homefirst Trust. The home is regulated by the Regulation and Quality Improvement Authority (RQIA).

Child protection:
A child is a person under the age of 18. The Children Order contains the legal definition.

Clinical and social care governance: (see "Governance")

Commissioned:
This means a service that is bought directly or on behalf of a provider organisation – such as a health board. It involves a contract and a specification which has to be monitored.

DHSSPS:
Department of Health, Social Services and Public Safety. Responsible for establishing policy and law for health and social services in Northern Ireland.

Governance:
In healthcare, this is about organisations having in place rigorous structures, processes, roles and responsibilities that enable them to provide good quality services, to monitor these and to improve them.

The phrase **"Clinical and social care governance"** also appears in the report.

It is about organisations taking responsibility for how they perform and providing guarantees for the standards of care they provide. It sets out how health and social service organisations are accountable for continuously improving and maintaining the quality of the services they provide.

It helps individuals and organisations who have to plan and deliver services to:

- identify the best practices and how to improve on them;
- assess and minimise the risk of things going wrong; and
- investigate problems as they arise and ensure lessons are learnt.

It helps professionals by ensuring the organisations they work for have systems in place to help them develop – for example, through training.

Homefirst Trust:
Homefirst Trust provided community and social services across a large part of Northern Ireland until 1 April 2007, when its services were integrated into the Northern Health and Social Care Trust. This is one of five new health and social care trusts set up under local government reorganisation in Northern Ireland.

LAC:
Children who are in the care of local authorities are described as Looked After Children.

Multi-disciplinary team:
A group of people from different disciplines (healthcare and non-healthcare) who work together to provide care for patients with a particular condition.

NHSSB (Northern Health and Social Services Board):
The Board's role is to commission health services. This means it must assess the health and social care needs of local people and plan, secure and pay for services to meet these needs.

NMC (Nursing and Midwifery Council):
The regulatory body in the United Kingdom for nurses.

Peer review:
Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved providing the service in the area that's being reviewed.

Quality:
There are many definitions of quality, such as "fitness for use", "customer satisfaction", "conformance to requirements". Each of these statements represents an aspect of quality.

Quality standards:
These are used in health and social services organisations, such as hospitals. They are issued by the DHSSPS. They provide guidance and standards that can be used to assess how the organisation is performing.

to provide a framework within and criteria against which organisational achievements and systems can be assessed and provides clear information to all stakeholders. The care standards (which are described earlier in this glossary) and quality standards are helpful to:

- people who use health and care services, by providing information on the quality of services they should receive;
- people and organisations that provide health and care services, by enabling them to measure and assess how well they are performing and the quality of the services they are providing; and
- the general public, by showing that systems are in place to promote consistently higher quality standards of care.

Regulated services:
These are health and social care services, such as those provided in nursing homes, residential homes and children's homes. They are inspected by staff from the Regulation and Quality Improvement Authority (RQIA).

RQIA (Regulation and Quality Improvement Authority):
An independent body which monitors and inspects the availability and quality of health and social care services and encourages service improvement.

Respite:
Temporary short-term breaks within or outside the family home.

Statutory:
A statute is a law. The report sometimes uses the phrases "statutory functions" and "statutory sector".

Statutory functions are duties that health and social care organisations have to carry out by law.

The statutory sector refers to organisations that have these legal duties, such as Trusts, Health Boards and agencies such as Barnardo's and RQIA.

Untoward incident:
Something that happens – for example, an accident, injury or an unexpected event – that requires further investigation.

Vulnerable adults:
A vulnerable adult is a person aged 18 years or over, who is or may be in need of community care services. They may be resident in a care facility due to illness or a mental or other disability. They may be unable to take care of themselves or unable to protect themselves against being harmed or exploited

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