REVIEW OF THE "SAFEGUARDS IN PLACE FOR CHILDREN AND VULNERABLE ADULTS IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS" IN HSC TRUSTS

OVERVIEW REPORT
RQIA - JUNE 2008

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EXECUTIVE SUMMARY

This thematic review by the RQIA was undertaken during September and October 2007 in all five Health and Social Care (HSC) trusts and was in response to a request from the DHSSPS for independent assurance that the necessary safeguards were in place for children and vulnerable adults in learning disability and mental health hospitals.

In particular, the review drew on the matters raised in correspondence (September 2006) from the Permanent Secretary at the DHSSPS to board and legacy trust chief executives requesting assurance in relation to the procedures in place within each trust to prevent abuse and to ensure that any incidents, which may arise, are dealt with properly.

The findings from this review have highlighted key elements of the work ongoing within HSC trusts in relation to child and adult protection and provide a baseline position against which future progress can be assessed.

Reviewers were able to evidence that whilst service users and carers were engaged in a variety of ways within all trusts, their participation in the delivery and evaluation of mental health services was very limited. The involvement of service users and carers in learning disability services was much better established. The review also highlighted that in the main, there was an absence of corporate policies in relation to service user and carer involvement.

Information returned from all trusts in relation to key training was of poor quality, therefore it was not possible to make direct comparisons across trusts in respect of the numbers and percentages of staff trained.

Within all trusts, review teams were informed that the admission of a child or young person to an adult ward was considered a Serious Adverse Incident and the DHSSPS, the Mental Health Commission and the commissioning Health and Social Services Board were formally notified. Trusts also reported that constant supervision was generally put in place for such children, individual rooms were allocated as far as possible and a strong emphasis placed on risk assessment throughout their stay, both in regard to the child and for other patients on the ward.

Based on the findings from this review, RQIA are concerned at the numbers of children being admitted to adult wards and the work that remains outstanding within HSC trusts to ensure all staff receive dedicated training in the areas of child and adult protection. In particular, trusts should:

- work in collaboration with the DHSSPS to minimise the numbers of children admitted to adult wards,
- ensure that child and adult protection training is provided in accordance with regional guidance, to all staff and volunteers working in mental health and learning disability services,
- fully implement the Regional Adult Protection Policy and Procedural Guidance[1],

[1] The Regional Adult Protection Policy and Procedural Guidance (DHSSPS, 2006)

- ensure that appropriate policies and procedures are in place for Looked After Children (LAC) and that all staff work in accordance with LAC guidance,
- ensure that information in relation to the named nurse and named doctor for child protection is made available to all staff

The recommendations made within both individual HSC trust reports and this overview report continue to be underpinned by regional child and adult protection policies and procedures, DHSSPS and other publications.

The findings from this review and any subsequent follow-up review will be shared with the minister for health, social services and public safety and made available in the context of open reporting.

1 SETTING THE SCENE

1.1 Regulation & Quality Improvement Authority - Role & Responsibilities

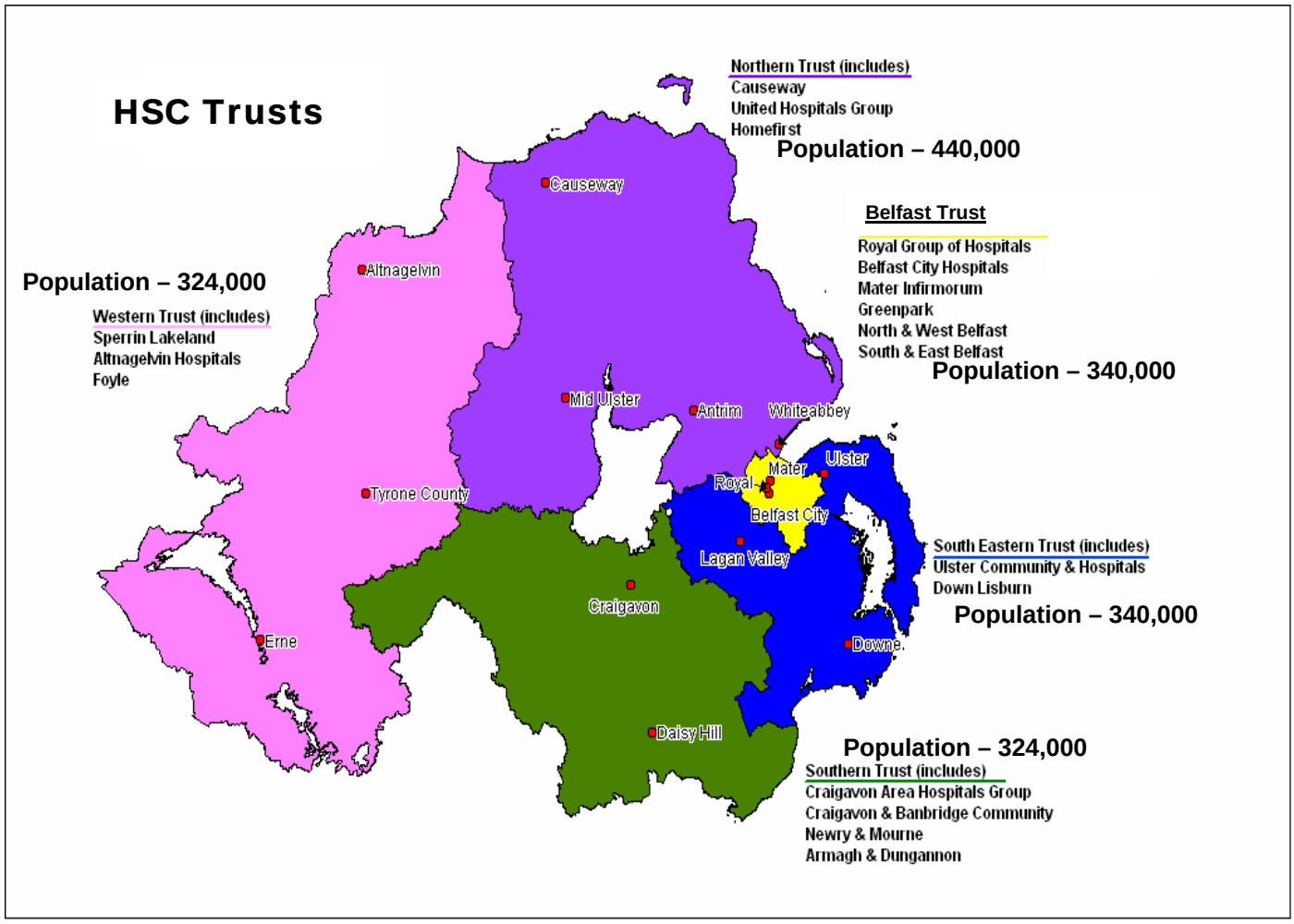
The Regulation and Quality Improvement Authority is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety, with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on Health and Social Care (HSC) organisations, and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfil its statutory responsibilities the RQIA has developed a planned programme of clinical and social care governance reviews of mental health and learning disability services within HSC organisations in N. Ireland. RQIA will also carry out commissioned reviews at the request of the DHSSPS.

Clinical and social care governance is described as a framework within which HSC organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

Table 1: Geographical Overview of HSC Trusts Reviewed



1.2 Safeguards for Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals

This thematic review was undertaken in response to a request from the DHSSPS for independent assurance that the necessary safeguards are in place for children and vulnerable adults in learning disability and mental health hospitals. In-patient mental health services are also provided in a range of units attached to general hospitals and these were also considered within the scope of this review. Throughout the report the term 'mental health hospitals' is used to describe the totality of hospital based mental health services.

This review evaluated those procedures in place within each HSC trust to prevent abuse and to ensure that any incidents, which may arise, are dealt with properly. In particular, the review drew on the matters raised in correspondence (September 2006) from the Permanent Secretary at the DHSSPS to board and legacy trust chief executives.

The review also examined the involvement of service users and carers, advocacy arrangements, voluntary sector involvement and key training for staff in relation to child and

adult protection. The review further considered the number of children and young people being admitted to adult wards in mental health and learning disability hospitals.

1.3 The Review Methodology

The RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems, which can identify performance standards and support the learning necessary for improvement. This review considered the systems in place within each trust to safeguard children and vulnerable adults within mental health and learning disability hospitals.

1.3.1 The Review Team

Review teams were multidisciplinary, and included both health and social care professionals (Peer Reviewers) and members of the public (Lay Reviewers) who had undertaken training as reviewers provided by the RQIA.

Lay reviewers came from a range of backgrounds and from all over Northern Ireland. They each played a vital role in review teams, bringing new insights and providing a lay person's perspective on all aspects of the provision of health and social care services.

Peer reviewers worked at a senior level in both clinical and non-clinical roles in HSC organisations. For this review, they had particular expertise in the areas of mental health, learning disability, child/adult protection and governance and possessed a commitment to improving health and social care.

Review teams were managed and supported by RQIA project managers and project administrators.

An identified leader for each review team worked closely with the RQIA project manager during the review to guide the team in its work and ensure that team members were in agreement about the assessment reached.

1.3.2 The Review Process

The review process had three key elements; self-assessment (including completion of self declaration), pre-visit analysis and the validation visit by the review team.

1.3.3 Self Assessment

Self-assessment is based on the statutory duty of quality as enshrined in the legislation and the underpinning requirements for HSC organisations to self assess their progress against the quality standards for health and social care. Self-assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally.

The methodology adopted within this review required trusts to complete self-assessment pro-forma and return this information to RQIA for analysis prior to validation visits by peer and lay reviewers. The questions asked within pro-forma were designed specifically by the RQIA to

capture relevant information and provide opportunity for trusts to present evidence of the safeguards in place for children and vulnerable adults within mental health and learning disability hospitals.

Article 34 of the HPSS (Quality Improvement and Regulation) (NI) Order 2003, places a statutory duty of quality on statutory organisations to; "put and keep in place arrangements for the purpose of monitoring and improving the health and personal social services that it provides to individuals; and the environment in which it provides them". In meeting this legislative responsibility, the trust chief executive signed a declaration confirming the accuracy of the self-assessment return to RQIA.

1.3.4 Pre-visit Analysis of Self Assessment

Self-assessment pro-forma and supporting evidence documentation were analysed by the RQIA review team prior to validation visits. The relevant information was collated onto an information system with commentary on the quality of information and evidence outlined in narrative on an analysis framework, which was then used by the review teams during validation visits.

1.3.5 The Review Visit

Review teams carried out reality testing of the self-assessment during the visits. Based on the initial analysis, review teams used a semi-structured interview schedule in relevant clinical and non-clinical areas. Enquiry was directed at staff, service users and their carers and centred on group and one-to-one interviews.

Reviewers also examined records (clinical/non clinical), relevant policies, procedures and protocols and directly observed clinical and non-clinical environments.

Initial feedback from the review team was given to each HSC trust at the end of the review visit outlining the findings of the review under the headings - strengths, challenges and exemplars.

1.3.6 Reports

Following each review visit, the RQIA project manager drafted trust specific reports detailing the findings of the review team and recommendations for improvement. This draft report was sent to the review team for comment, and then to the organisation to check for factual accuracy.

Once agreement was reached, RQIA compiled an overview report for the DHSSPS on the overall findings of the review across all HSC trusts.

The overview report is made available to the general public in print, the RQIA web site and other formats on request.

2 SERVICES WITHIN TRUSTS

At the time of the review, the new HSC trusts in Northern Ireland were in the very early stages of development following the merging of legacy trusts. These mergers created a considerable challenge for organisations in the development of trust-wide policies and procedures.

Services were to a large extent still organised along legacy trust lines and the self-assessment information returned by trusts generally reflected this approach and as a consequence, findings are at times described in terms of settings.

2.1 General Overview

Trusts' submitted proforma for each mental health and learning disability hospital within their geography. This information is presented in Table 2.

Across all trusts, reviewers were generally impressed with the caring, conscientious and open approach of staff to the vulnerable people in their care and the loyalty shown to the employing trust. Staff demonstrated commitment and dedication to providing the best and safest care possible and were co-operative and helpful in providing information to reviewers. Service users who spoke with reviewers were in the main, complimentary of staff and of the care being provided.
As the focus of this review was on the safeguards in place for children and vulnerable adults within mental health and learning disability hospitals, reviewers did not overly focus on environmental issues. It is acknowledged however, that within individual trust reports, mention has been made of specific issues relevant to reviewers' findings.

Table 2: Mental Health and Learning Disability Hospitals

Trust	Mental Health Hospital	Learning Disability Hospitals
Belfast HSC Trust	Belfast City Hospital Donard Unit (In-patient Adolescent Unit at Knockbracken) Family and Child Psychiatry Unit (located at Forster Green Hospital) Knockbracken Hospital Mater Hospital	Muckamore Abbey Hospital
Northern HSC Trust	Holywell Hospital Causeway Hospital Whiteabbey Hospital	
South Eastern HSC Trust	Ards Hospital Downshire Hospital Lagan Valley Hospital	
Southern HSC Trust	Craigavon Hospital St Luke's Hospital	Longstone Hospital
Western HSC Trust	Gransha Hospital Tyrone & Fermanagh Hospital	Lakeview Hospital

3 TRUST RESPONSES TO CORRESPONDENCE FROM THE PERMANENT SECRETARY

This section of the report focuses on the matters raised in correspondence from the permanent secretary to trust chief executives in relation to the following four issues: -

- Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff,
- Appropriate child and vulnerable adult protection procedures are in place with regard to the recruitment, supervision and management of staff,
- Recording and reporting mechanisms, both within the trust and to appropriate external agencies, are in place, understood by staff and adhered to, and
- Appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied.

3.1 Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff

All HSC trusts reported that risk and vulnerability assessment processes were in place to take account of the risk of abuse presented by patients either to themselves, other patients or members of staff.

The Belfast HSC Trust reported that comprehensive risk assessment processes were in place across all mental health and learning disability hospital sites to manage the risk of abuse. A clinical risk assessment group has been established in Muckamore Abbey Hospital and the review team noted that initial risk assessment was undertaken for all children admitted to the hospital with further risk assessment and management plans put in place to safeguard children when they are admitted to adult wards. The evidence gathered through site visits satisfied the review team that staff were proactive in the prevention and management of risk.

When a child or young person was admitted to an adult ward within the Northern HSC Trust, a multi-disciplinary meeting was convened to address all risk factors associated with that admission including those risks posed by patients currently on the ward.

In the South Eastern HSC Trust the review team was satisfied that risk assessment was carried out in those inpatient settings visited although had some concerns that the risk assessment tool being used did not adequately address the particular needs of children or young people whilst inpatients on adult wards.

In the Southern HSC Trust, the review team was satisfied with the risk assessment and pre-admission planning and processes in place. However a risk assessment tool examined by the review team in the Craigavon Psychiatric Unit did not provide the necessary detail and analysis to allow for the development of a clear management plan, including the management of risk presented by patients either to other patients or to members of staff. Within Longstone Hospital, a comprehensive process of risk management is undertaken on admission, using the Salford Tool. The review team evidenced that policies and procedures had been implemented in relation to forensic clients and the risks posed to other vulnerable patients. Furthermore, the accommodation within the Interim Assessment and Treatment Unit (IATU) allowed for the separation of male and female living areas when this was deemed necessary.

Whilst the Western HSC Trust had in place risk assessment tools that took account of the risk of abuse, there was evidence that all relevant staff had not received training on their use. Training provision in this area was variable, and noticeably absent within the learning disability programme. The review team also reported variability in staff insights and levels of understanding and knowledge around the concept of risk assessment. Within Lakeview Hospital, the review team were advised that a risk assessment tool being piloted within the learning disability programme alerted hospital staff to patient's traits, behaviours and propensities, which could pose a risk to self or other patients. An untoward incident monitoring group reviewed all incidents on a monthly basis and included representation from the trust's risk management department.

3.2 Appropriate Child and Vulnerable Adult Protection Procedures are in place with regard to the recruitment, supervision and management of staff

All HSC trusts reported through their self assessment returns that a series of pre-employment checks on staff and volunteers were undertaken and which included for example, Protection of Children and Vulnerable Adults (POCVA), Occupational Health, references, (including current employer) professional registration, qualifications, proof of identity and checks in relation to continuous employment or breaks in service.

The self assessment returns and the information provided to review teams during site visits indicated that whilst arrangements for supervision and appraisal were generally in place, these were not always being applied consistently. Delays in fully assimilating staff unto 'Agenda for Change' has adversely impacted on rolling out the knowledge and skills framework. Furthermore, the review teams also noted that the regional guidance for the Clinical Supervision for Mental Health Nurses had not been consistently applied within all mental health hospitals.

RECOMMENDATION:

Trusts should establish robust individual and group supervision structures, which take into account the relevant professional guidelines and ensure that supervision is embedded throughout all professional groups.

3.3 Recording and reporting mechanisms, both within the Trust and to appropriate external agencies, are in place understood by staff and adhered to

Trust self-assessment returns indicated that recording and reporting mechanisms were in place to notify senior trust staff, Health and Social Services Boards, the DHSSPS and the Mental Health Commission of all Serious Adverse Incidents. The evidence elicited by review teams during site visits indicated that arrangements were in place within all trusts to enable the analysis of trends; learning from incidents and for feedback to front line staff through a variety of mechanisms that included ward manager meetings, staff meetings and team briefs.

Members of staff who were interviewed by review teams were familiar with incident reporting procedures, appeared open to reporting incidents and recognised the channels of accountability for incident reporting.

3.4 Appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied

It is acknowledged that at the time of this review, HSC trusts were endeavouring to co-ordinate and harmonise all legacy trust policies and procedures, which has presented as a considerable challenge. Self-assessment returns indicated that within each HSC trust, a Child Protection Committee was in place and Area Child Protection Committees (ACPC) Policies and Procedures were available and accessible to all staff working within mental health and learning disability hospitals. However work was still required to ensure the regional adult protection guidance was fully implemented within all HSC trusts.

3.4.1 Policies and Procedures

The Belfast HSC Trust reported that a range of processes were in place to review and update policies, procedures and protocols to take account of legislative change and new/revised best practice guidance. Within the Mater Hospital, the review team was satisfied that a robust policy was in place, which ensured the delivery of safe and effective care to children. The review team was also impressed with the liaison arrangements with Child and Adolescent Mental Health (CAMH) services. A range of initiatives have been put in place in Muckamore Abbey following publication of the Social Services Inspectorate report (DHSSPS, 2003) which included; designated Child Protection Nurse specialists supporting Muckamore Abbey Hospital, hospital representation on trust child protection panel and the establishment of a hospital child protection steering group. Whilst the very significant action taken in response to child protection is acknowledged, a number staff who spoke with the review team in Fintona North and Finglass Wards, were not aware of who had lead responsibility for adult protection.

The Northern HSC Trust reported that there were policies and procedures in place regarding the admission and management of young people and vulnerable adults in hospital. The review team was informed that the senior nurse for child protection was responsible for all child protection arrangements, which included the provision of awareness training, the provision of advice/guidance to mental health staff and the induction of new staff.

The South Eastern HSC Trust had set up a trust-wide safeguarding children project to examine trust-wide processes and communications that included defining roles, responsibilities and lines of accountability. This project demonstrated a good example of

collaborative working between mental health and child care services. The trust stated members of staff had been trained to act as 'Safeguarding Children Advisors', which provided staff with a point of contact for information and advice.

Within the Southern HSC Trust, staff interviewed in Craigavon Psychiatric Unit were knowledgeable about child protection issues and were aware of their roles and responsibilities, legislative requirements, statutory functions and patient and carer rights. However, other members of staff interviewed had not received sufficient training and were unable to demonstrate good awareness of child protection issues.

Within the Western HSC Trust, the review team were complimentary of the robust policies and procedures in place governing the admission of children and young people to adult mental health and learning disability wards and of the awareness of staff in putting in place the necessary safeguards.

3.4.2 Looked After Children (LAC) review and audit activity

The information returned from HSC trusts, indicated that within the Belfast, Southern and Western HSC Trusts, reviews had been undertaken in accordance with LAC guidance although LAC reviews were not always subject to audit activity.

The Northern HSC Trust reported that LAC review associated audit activity was 'not applicable' within mental health services, although during site visits, the review team identified at least two cases, which should have been taken forward in accordance with LAC guidance.

The South Eastern HSC Trust reported that LAC reviews were undertaken within Lagan Valley Hospital but not within the psychiatric unit at Ards Hospital or the Downshire Hospital. Notwithstanding, the trust also reported that in 2004/05, one young person had been in the Ards Psychiatric Unit for 176 days. Members of staff who were questioned by the review team regarding the LAC guidance were unaware of the procedures and arrangements and there was no indication from the files examined that any LAC procedures were being followed.

3.4.3 Named Nurse & Named Doctor for Child Protection

Self-assessment returns indicated that within each HSC trust, arrangements were in place to ensure the availability of a named nurse and named doctor for child protection. Within the Southern and South Eastern HSC Trusts, it was further reported that the role of named nurse and named doctor was supported through contact arrangements with Child Protection Nurse specialists.

However, the review team noted that within those wards visited in the Belfast HSC Trust, a number of staff were unaware of the identity of the named doctor for child protection.

Within the South Eastern HSC Trust, a number of staff working in Ards Psychiatric Unit were unable to identify either the named nurse or named doctor with responsibility for child protection.

Similarly, within the Northern HSC Trust, a number of staff within the Ross Thompson Unit did not know the identity of the named doctor with responsibility for child protection.

3.4.4 Children as Visitors

At the time of this review, draft policies in relation to children as visitors were in place within the Belfast, South Eastern and Western HSC Trusts.

However, there was no policy in place within either the Northern or Southern HSC Trusts outlining the arrangements for children visiting adult wards or in relation to children whose parents had been admitted to mental health hospitals.

RECOMMENDATIONS:

Trusts should ensure that appropriate policies and procedures are in place for Looked After Children (LAC) and that all staff work in accordance with LAC guidance.

Trusts should ensure that information in relation to the named nurse and named doctor for child protection is made available to all staff.

4 SERVICE USER INVOLVEMENT AND ADVOCACY ARRANGEMENTS

Through this review, review team members met service users, carers and advocates in a number of ways that included individual and group interviews, incidental discussion during site visits and formal meetings. Whilst reviewers were able to evidence that service users and carers were engaged in a variety of ways within all trusts, their participation in the delivery and evaluation of mental health services was very limited. However, reviewers noted that the involvement of service users and carers in learning disability services was much better established. There was also in the main, an absence of corporate policies in relation to service user and carer involvement.

Trust self assessment returns and the evidence obtained by reviewers through on-site visits indicated that partnership working with a range of different groups and advocacy services was in place across all trusts; however in a number of settings these arrangements required further development.

Reviewers were complimentary of the arrangements in place within learning disability hospitals to engage patients and carers and provide independent advocacy services. Opportunities therefore exist within trusts for shared learning between learning disability and metal health services and settings to further develop this important area.

4.1 Involvement of Service Users and Carers

Public and service user involvement is one of the fundamental principles which underpins the Quality Standards for Health and Social Care and the views and experiences of service users, carers, staff and local communities should be taken into account in the planning, delivery, evaluation and review of services.

Belfast Health & Social Care Trust
Across all mental health services within the trust there was good evidence of service user and carer involvement. At the time of the review, a service user consultant post was being advertised which represented a unique initiative in Northern Ireland.

Within Muckamore Abbey Hospital, the review team commented on the open and transparent culture and the involvement of non-statutory organisations in the planning, delivery and evaluation of care. A number of wards within the hospital had patient/carer forums as well as a larger day care forum which in the main acted to safeguard patients' rights but has in the past provided a service user perspective on significant capital and policy developments.

Northern Health & Social Care Trust
The trust did not have a policy in place in relation to service user and carer involvement although senior managers were able to demonstrate to the review team how service users had been enabled to become involved in policy development. On the Holywell Hospital site, a public advisory group had been involved with the hospital management team in strategy planning and the development of new services and examples were provided to the review team of how service users helped shape services such as "*The Oasis*". On the Whiteabbey Hospital site, the review team found there was no mechanism in place to obtain feedback from service users on their experiences of the care provided.

South Eastern Health & Social Care Trust
Whilst it is acknowledged that a 'Mental Health Alliance' of service users and carers was in place within the trust, no service users or carer representatives were available to meet with

the review team on the Downshire site and the review team were of the opinion that service user and carer involvement in the planning, delivery and evaluation of services was limited. However, within the Ards Psychiatric Unit, the review team were satisfied with the examples of good practice that were shared with them in relation to the operational involvement of service users and carers.

Southern Health & Social Care Trust

The Assistant Director for Health and Wellbeing has been tasked with the development of service user involvement strategies, including monitoring, feedback and action planning to encourage public involvement. Service user and carer forums were operational within some areas of the trust although the actual involvement of service users and their carers was variable. Within St Luke's Hospital, service users and carers were involved in the 'Mind the Gap Project' and the ongoing evaluation of home treatment. The review team noted that whilst patients were given opportunity to voice concerns during impromptu meetings in the Craigavon Psychiatric Unit, this appeared to be driven by the needs of the service rather than service users. Within Longstone Hospital, the review team witnessed good rapport and interaction between patients and staff during site visits.

Western Health & Social Care Trust

At the time of the review the trust had yet to formalise the involvement of service users/carers at a strategic level to ensure a more patient centred approach was taken in relation to the planning and implementation of mental health services. A mental health 'Acute Care' forum was in place and the review team were able to evidence service user and carer involvement in the development and improvement of practice. However, those carers who met with the review team expressed a desire for greater inclusion in relation to admission and discharge processes.

4.2 Advocacy Arrangements & Voluntary Sector Involvement

In 2003, a review was undertaken at the behest of The Northern Ireland Human Rights Commission examining the human rights issues associated with mental health law and practice. In 'Connecting Mental Health and Human Rights[2]', the authors noted that "there is no right to representation or advocacy under The Mental Health (Northern Ireland) Order 1986, and people are not automatically offered or allocated a lawyer or advocate". The report concluded that the need for advocacy and voluntary sector involvement in mental health services is critical to ensure that the human rights of service users are fully upheld through all aspects of the care pathway, which for some service users may be life-long. These conclusions are equally applicable to learning disability services.

Belfast Health & Social Care Trust

The trust highlighted their commitment to using advocacy services and the review team evidenced this during site visits. Advocacy services were provided by a range of organisations, for example, the NI Association for Mental Health (NIAMH), (CAUSE), Bryson House, Voice of Young People in Care (VOYPIC), and the Chinese Welfare Association.

Within Forster Green Hospital whilst there was no independent advocacy arrangements in place, the review team was informed of discussions with NIAMH and CAUSE to develop this

[2] 'Connecting Mental Health and Human Rights' (Northern Ireland Human Rights Commission, 2003)

initiative. Notwithstanding, at the time of this review, a patient advocate service was involved in obtaining children's views in relation to the plans for a new build and associated service developments although this involvement was not on an ongoing basis.

Within Muckamore Abbey Hospital, the review team noted the strong drive to enhance advocacy and service user involvement through the use of independent organisations such as Bryson House and Mencap.

Northern Health & Social Care Trust

Independent advocacy services were available throughout the trust and a service level agreement was in place with NIAMH although this service was not available out of hours. During site visits, the review team observed posters for the mental health charity "Rethink" and the Citizens Advice Bureau.

South Eastern Health & Social Care Trust

The trust indicated that independent advocacy arrangements were in place for all mental health service users. The review team observed that posters and leaflets advising service users about advocacy services were readily available and staff reported that service users are informed about advocacy services on admission and throughout their treatment. On the Ards Hospital site, the review team evidenced good partnership working between advocates and staff, however due to the variety of advocacy services available, staff were not always clear about which service was best for particular service users. On the Lagan Valley site, a number of staff interviewed were unable to provide information in relation to the advocacy services available.

Southern Health & Social Care Trust

A number of voluntary sector organisations were involved in partnership working with the trust, for example, Praxis and NIAMH, Mencap, Downs Syndrome Association but the trust itself did not use volunteers. The review team noted that trust involvement was through service user advocates and carer representatives. At the time of this review, Mencap was providing an independent advocacy service within Longstone Hospital and although the service was only provided 8 hours per week, it covered a caseload of approximately 170 patients.

Western Health & Social Care Trust

Advocacy services were provided to relatives and carers of people with mental health problems by the peer led mental health charity, CAUSE. A service user group '*Heads Together'* represented the general views of service users and representatives from that group were key members on the Acute Care Forum and other relevant committees. The review team also evidenced the involvement of a number of self-help organisations, for example, "*Foyle Advocates*" and "*Mind Yourself*".

Within the learning disability programme, the trust commissioned advocacy services from a group known as the Western Area Learning Disability Action Group (WALDAG), an umbrella organisation, made up of parents and friends of patients with a learning disability. In addition to providing independent advocacy for a named group of patients, WALDAG have also contributed to the planning and development of Lakeview Hospital and at the time of the review were involved in the development of a replacement facility for Mourne House. Arrangements were also in place that enabled WALDAG to advocate for patients within a local nursing home.

RECOMMENDATIONS:

In addressing the HPSS Quality Standards for Health and Social Care, HSC trusts should continue to develop policies and procedures that actively engage service users and their carers in the planning, delivery and evaluation of mental health and learning disability services.

Trusts should develop clear service user and carer involvement strategies that set out how service users, carers, volunteers, staff and local communities can be actively involved in the planning, delivery, evaluation and review of mental health and learning disability services.

5 KEY TRAINING FOR STAFF AND VOLUNTEERS

Training is a key requirement for safeguarding children and vulnerable adults in mental health and learning disability hospitals. Analysis of a number of Serious Adverse Incident reviews indicated that specific training should be provided to all staff and volunteers in the areas of child protection, adult protection and the management of aggression and challenging behaviour.

Information returned from all HSC trusts in relation to key training was of poor quality, therefore it was not possible to make direct comparisons across trusts in respect of the numbers and percentages of staff trained.

5.1 Child Protection Training

The Area Child Protection Committees' (ACPC) Regional Policy and Procedures[3] state, "*Effective child protection depends on the knowledge and judgment of all staff working directly with children and those who provide guidance, supervision and direction. It is important; therefore that staff in direct contact with children and those in supervisory and management positions receive relevant training. Training should be tailored to meet the needs of different staff*". In 'Co-operating to Safeguard Children[4]' three levels of training are detailed to meet the needs of staff based on their roles and responsibilities. These are described in Table 3.

Table 3: Stages of Child Protection Training

Stages of Child Protection Training	
Stage One	Introduction to the safeguarding of children, having regular contact with children and/or parents
Stage Two	Foundation training for staff working with children and families where there may be a high risk of significant harm, but the staff are not involved directly in child protection services
Stage Three	Specialist training for staff directly involved in investigation, assessment and intervention to protect children considered to be at risk of significant harm

In applying this guidance, there is an expectation that at a minimum, all staff working in mental health and learning disability services should be trained to stage one. Training at stages 2 and 3 should be provided to staff working in more specialist areas. The provision of dedicated child protection training is essential for the provision of safe and effective services. Within this review, trusts were asked to provide information on the numbers of staff who received formal child protection training over a 3-year period (2004/05–2006/07). This information is presented in Table 4.

The information returned from trusts indicated that there had been limited provision of child protection training for staff working within mental health and learning disability hospitals and the figures presented in Table 4 indicated that not all staff had received stage 1 training. This was supported by review teams findings in a number of areas, for example, at the time of this review, no formal training had been provided to staff working in the Ross Thompson Unit (Northern HSC Trust) and the Ards Psychiatric Unit (South Eastern HSC Trust).

The review team also noted that in the main, child protection training was almost exclusively taken up by nursing staff with little involvement of medical and other clinical and non-clinical grades of staff.

The review team evidenced that all staff in Donard Regional Adolescent Unit had been trained to stage 2.

[3] Area Child Protection Committees' Regional Policy and Procedures (DHSSPS, 2005)
[4] Co-operating to Safeguard Children (DHSSPS, 2003)

Table 4 - Child Protection Training in Mental Health and Learning Disability Hospitals

Child Protection Training	2004 - 2005 Number of staff trained	2005 – 2006 Number of staff trained	2006 – 2007 Number of staff trained
Stage 1			
Belfast HSC Trust	10	86	142
Northern HSC Trust	0	63	12
South Eastern HSC Trust	15	35	25
Southern HSC Trust	56	70	70
Western HSC Trust	0	0	181
Stage 2			
Belfast HSC Trust	0	21	4
Northern HSC Trust	0	0	0
South Eastern HSC Trust	0	0	15
Southern HSC Trust	0	0	0
Western HSC Trust	0	0	0
Stage 3			
Belfast HSC Trust	0	3	0
Northern HSC Trust	0	0	0
South Eastern HSC Trust	0	0	14
Southern HSC Trust	0	0	0
Western HSC Trust	0	0	0

Within the Southern HSC Trust, staff within the two identified adult wards which admit children (Interim Assessment and Treatment Unit at Longstone and Cloughmore Ward at St Luke's) had been prioritised for child protection training although no evidence was found indicating staff had been trained to stage 2.

Ward staff at Lagan Valley Hospital told the review team that child protection training was not provided, as children were not admitted to the ward. However, this fails to take into account the number of service users who had children as dependents or visitors.

5.2 Adult Protection Training

The Regional Guidance states that the *"procedures detail the processes that must be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect".* It is important therefore that all staff receive dedicated training in relation to adult protection, are familiar with the regional guidance document and work in accordance with it.

The self-assessment returns from all trusts for the 3-year period (2004/05–2006/07) indicated that only very small numbers of staff had been provided with formal training on adult protection, for example, the information returned from the Northern, Western and South Eastern HSC Trusts indicated that a total of only 85 staff received training on adult protection

(over the three year period 2004-2007) within both mental health and learning disability hospitals.

Staff informed the review teams that local adult protection policies and procedures were still in use within the Belfast and Northern HSC Trusts despite those organisations having endorsed the regional guidance.

5.3 Management of Challenging Behaviour and Aggression Training

Within all trusts, the review teams were advised that training on the management of challenging behaviour and aggression was mandatory for all staff. However the information submitted by trusts in relation to the numbers of staff who had accessed this training over the three-year period (2004-2007) did not support this contention. The relatively low numbers suggest that not all staff had received training.

Analysis of trust self assessment returns and information obtained by review teams during site visits indicated that dedicated training on the management of aggression and challenging behaviour was principally uni-disciplinary and in the main provided to nursing staff by nursing staff. Other clinical and non-clinical staff did not always have access to this important training.

Within legacy trusts, training had been commissioned from a range of different providers, e.g. Management of Aggression and Potential Aggression (MAPA), Honestas, Educare and Social Services Training Units. Therefore, within new trust structures, the potential exists for conflict between the various methodologies in use and within the Southern HSC Trust staff voiced this concern to the review team.

5.4 Volunteer Training

In the main, there was very limited use of volunteers in mental health hospital services within all trusts. Where volunteers were used, this was by way of service level agreements with a number of voluntary organisations that were responsible for providing training to their staff. There was no indication from the information submitted by trusts or through review visits that the training provided had been quality assured by the commissioning trust. Furthermore, mandatory training provided to staff e.g. child and adult protection and the management of aggression was not always made available to volunteers.

Within learning disability hospitals, there was a higher reported level of engagement with volunteers; in particular, the Western HSC Trust self-assessment returns indicated that for Lakeview Hospital, 100 volunteers had been trained in 2004/05; 130 in 2005/06 and 168 in 2006/07. Volunteer input was specific to a four-week summer scheme activity programme for children with a learning disability based within Lakeview Hospital. All volunteers were POVCA checked and were issued with an honorary contract.

In Muckamore Abbey Hospital, there was limited volunteer provision in the wards visited, however volunteers were utilised within the hospital in a range of settings and at the time of this review, the trust was in the process of identifying the training needs of volunteers.

RECOMMENDATIONS:

Trusts should develop information systems, which ensure that details of attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

Trusts should ensure that child protection training is provided (in accordance with regional guidance) to all staff and volunteers working in mental health and learning disability services.

Trusts should ensure that adult protection training is provided to all staff and volunteers working in mental health and learning disability services.

Trusts should ensure that all staff (clinical and non-clinical) and volunteers working in mental health and learning disability services are formally trained in the management of aggression / challenging behaviour.

Trusts should adopt a consistent approach to the management of aggression.

Trusts should ensure that the training provided by those organisations from which it commissions services is of a satisfactory standard.

6 CHILDREN & YOUNG PEOPLE IN MENTAL HEALTH AND LEARNING DISABILITY HOSPITALS AS PATIENTS

Within the self-assessment pro-forma, trusts were asked to report the number of children and young people inappropriately admitted to adult wards within mental health and learning disability hospitals. Within all trusts, review teams were informed that the admission of a child or young person to an adult ward was considered a Serious Adverse Incident and the DHSSPS, the Mental Health Commission and commissioning HSS Board were formally notified.

Trusts also reported that constant supervision was generally put in place for such children, individual rooms were allocated as far as possible and a strong emphasis placed on risk assessment throughout their stay, both in regard to the child and for other patients on the ward. The admission of children and young people to adult mental health and learning disability wards is an issue that requires urgent action on a regional basis.

6.1 Children & Young People in Mental Health Hospitals as Patients

In the Belfast, South Eastern and Southern HSC Trusts, the review team evidenced that policies and protocols were in place to manage the placement of children and young people on adult wards and for those staff providing their care.

At the time of this review, the Belfast HSC Trust was in discussion with CAMH services to enhance the interface with adult services to more effectively address the needs of children and young people being cared for on adult wards The review team was informed that additional dedicated teams were to be established to deal with crisis response and out of hours services for adolescents.

Within the Northern HSC Trust, two nurses in Holywell Hospital had completed additional training through Queens University Belfast in relation to adolescent mental health and when children or young people required admission to an adult ward, the trust endeavoured to provide such placements in Holywell Hospital. Similar arrangements were reported in the Belfast and Southern HSC Trusts.

Within the Western HSC Trust, the review team was complimentary of a forum that had been established in conjunction with the Western Health and Social Services Board which monitored and audited the issue of children being placed on adult wards.

The number of children and young people admitted to mental health hospitals and the total length of stay reported by HSC trusts is illustrated in Table 5.

Analysis of the information returned from trusts indicated that there were a total of 273 admissions of children and young people to adult wards in mental health hospitals over the period 2004 – 2007. Whilst it was difficult to undertake further analysis of this information in the absence of a greater understanding of the drivers for admission, the data returned indicated that 94 admissions (34%) occurred within the Western HSC Trust.

Table 5 - Children & Young People in Mental Health Hospitals as Patients

Total Number of Children & Young People (< 18 yrs) who spend time as patients in adult wards (average length of stay in brackets)		2004-2005	2005-2006	2006-2007
Belfast HSC Trust	Knockbracken*	10 (14.6 days)	5 (39.2 days)	2 (7 days)
	Mater	0	9 (56 days)	8 (29 days)
	Windsor	5 (10.6days)	5 (23 days)	4 (14.7 days)
Northern HSC Trust	Holywell	14 (46 days)	11 (38 days)	7 (57 days)
	Ross Thompson	3 (21 days)	11 (21 days)	2 (71 days)
	Whiteabbey	0	0	0
South Eastern HSC Trust	Downshire	7 (23 days)	2 (26 days)	1 (25 days)
	Lagan Valley	11 (5 days)	6 (58 days)	4 (33 days)
	Ards	1 (176 days)	5 (104 days)	5 (46 days)
Southern HSC Trust	Craigavon**	17 (24 days)	15 (46 days)	6 (60 days)
	St Luke's	2 (3 days)	0	1 (6 days)
Western HSC Trust	Gransha	21 (15 days)	16 (31 days)	15 (25 days)
	Tyrone & Fermanagh	16 (21.4 days)	14 (17.3 days)	12 (16.3 days)

Notes:

* *Donard Ward (Knockbracken) and the Child and Family Unit at Forster Green Hospital are specialist services for children and young people and therefore admissions to these units are not included in the figures.*

** *These figures also include those children and young people admitted to Cloughmore Ward on the St. Luke's Hospital site.*

6.2 Children & Young People in Learning Disability Hospitals as Patients

Muckamore Abbey Hospital

A policy was in place, which set out very specific responsibilities when a child required placement on an adult ward. The review team were informed that such children were placed at the highest level of supervision; risk assessments were completed and additional safeguards put in place as necessary.

Lakeview Hospital
Staff, working both in the children's unit in Lakeview Hospital and throughout the trust were knowledgeable with regard to the ACPC child protection guidance and were clear about safeguards that should be put in place when children spend time on adult wards.

During the site visit to Lakeview Hospital, the review team became aware that there were significant periods of time when a registered nurse was not always present on Crannog Lodge particularly during the evening and at night. This issue was brought to the attention of the Director and the trust subsequently made provision for trained night cover within Crannog Lodge.

Longstone Hospital
At the time of the review, Longstone Hospital had a draft protocol for the admissions of under 18's to the Interim Assessment and Treatment Unit, which was out for consultation. This protocol included the requirement that each admission of an under 18 must be reported but did not state the mechanisms for reporting or who would take responsibility at each stage of the process. The review team felt the draft policy should include timeframes, including immediate allocation of one to one supervision prior to placement of a child on the ward. Following the review, the trust has taken action to ratify this policy.

The number of children and young people admitted to learning disability hospitals and the total length of stay reported by trusts is illustrated in Table 6.

Table 6 - Children & Young People in Learning Disability Hospitals as Patients

Total Number of Children & Young People (< 18 yrs) who spend time as patients in adult wards (average length of stay in brackets)		**2004-2005**	**2005-2006**	**2006-2007**
Belfast HSC Trust	Muckamore	10 (201.6 days)	11 (140.2 days)	7 (161.4days)
Southern HSC Trust	Longstone	4 (128 days)	4 (240 days)	2 (75 days)
Western HSC Trust	Lakeview	9 (49 days)	8 (41 days)	6 (15 days)

RECOMMENDATION:

The DHSSPS should work closely with HSC organisations to minimise the number of children and young people admitted to adult wards in mental health and learning disability hospitals.

6.3 Child Protection Investigations

Within the self-assessment returns, HSC trusts were asked to report on the number of child protection investigations undertaken during the 3-year period 2004-2007. The Northern, South Eastern and Southern HSC Trusts reported that no child protection investigations had been undertaken in relation to hospital services.

Within the Belfast HSC Trust, 6 investigations had been carried out of which 1 allegation had been substantiated and 4 unsubstantiated. At the time of this review, 1 investigation was still ongoing.

Within the Western HSC Trust, whilst 2 investigations had been undertaken, the allegations were unsubstantiated.

6.4 Adult Protection Investigations

At the time of this review, the review team had an expectation that all trust staff would be working in accordance with the regional adult protection guidance. However the review team noted that local legacy trust policies and procedures continued to be in use in a number of sites visited and copies of the regional guidance was not always available within facilities. This was particularly the case within the Belfast and Northern HSC Trusts.

Within self assessment returns, HSC trusts were asked to report on the number of adult protection investigations undertaken during the 3 year period 2004-2007. However, the information returned in relation to mental health hospitals was at times incomplete or inaccurate. As a consequence, it is not possible to provide a regional overview of the number of investigations undertaken.

In relation to the number of adult protection investigations undertaken within learning disability hospitals, the information provided was of a much higher quality allowing for the following overview to be presented.

Table 7 – Number of Adult protection Investigations in Learning Disability Hospitals

Hospital	Substantiated allegations	Unsubstantiated allegations
Muckamore Abbey	3	23
Longstone	3	1
Lakeview	3	6

Whilst this review did not examine the nature of substantiated abuse, the information returned from HSC trusts indicated that in the main, substantiated incidents of abuse were of a physical nature.

RECOMMENDATION:

Trusts should fully implement the Regional Adult Protection Policy and Procedural Guidance.

7.0 CONCLUSION

This overview report which is further informed by the individual trust reports sets out the performance of trusts in relation to the safeguards in place for children and vulnerable adults within mental health hospitals and learning disability hospitals.

This review focused on policy and procedural development, the numbers of children and young people treated in adult wards and the relevant areas of training for staff in child and adult protection. In particular, the review drew on the matters raised in correspondence from the permanent secretary to legacy trust chief executives.

As part of the review process, trusts were provided with immediate feedback on the findings of the individual review teams. This feedback was based on the challenges and strengths identified within each trust. Whilst there were a significant number of examples of good practice identified throughout the review, RQIA are concerned at the work that remains outstanding within all trusts, especially in relation to the deficits in staff training and the numbers of children and young people being treated on adult wards.

Within new trust structures, the opportunity now exists for organisations to work much more collaboratively to take this work forward in a consistent and cohesive manner. Within this overview report, RQIA recommends that HSC organisations work collaboratively with the DHSSPS to address the significant issue of children and young people being admitted to adult wards.

8.0 SUMMARY OF KEY RECOMMENDATIONS

User Involvement

- In addressing The Quality Standards for Health and Social Care, HSC trusts should continue to develop policies and procedures that actively engage service users and their carers in the planning, delivery and evaluation of mental health and learning disability services.

- Trusts should develop clear service user and carer involvement strategies that set out how service users, carers, volunteers, staff and local communities can be actively involved in the planning, delivery, evaluation and review of mental health and learning disability services.

Recruitment, supervision and management of staff procedures

- Trusts should establish robust individual and group supervision structures, which take in to account the relevant professional guidelines and ensure that supervision is embedded throughout all professional groups.

Appropriate policies and procedures

- Trusts should ensure that appropriate policies and procedures are in place for Looked After Children (LAC) and that all staff work in accordance with LAC guidance.

- Trusts should ensure that information in relation to the named nurse and named doctor for child protection is made available to all staff.

Key Training for Staff and Volunteers

- Trusts should develop information systems, which ensure that details of attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

- Trusts should ensure that child protection training is provided (in accordance with regional guidance) to all staff and volunteers working in mental health and learning disability services.

- Trusts should ensure that adult protection training is provided to all staff and volunteers working in mental health and learning disability services.

- Trusts should ensure that all staff (clinical and non-clinical) and volunteers working in mental health and learning disability services are formally trained in the management of aggression / challenging behaviour.

- Trusts should adopt a consistent approach to the management of aggression.

- Trusts should ensure that the training provided by those organisations from which it commissions services is of a satisfactory standard.

Children and Young People in Adult Wards

- The DHSSPS should work closely with HSC organisations to minimise the number of children and young people admitted to adult wards in mental health and learning disability hospitals.

Adult Protection Guidance

- Trusts should fully implement the Regional Adult Protection Policy and Procedural Guidance.

Appendix 1 – Peer and Lay Reviewer

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Appendix 2 – RQIA Project Team

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Appendix 3 - Glossary of Key Terms & Abbreviations

Glossary of Key Terms & Abbreviations

Term	Definition
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Adverse incident	An incident, accident or occurrence, relating to systems or procedures which results in harm, or an injury, or near miss to a patient, member of staff or the public.
Appraisal	Examination of people or the services they provide in order to judge their professional qualities, successes or needs.
Audit	The process of measuring the quality of services against explicit standards.
CAMH Services	Child and Adolescent Mental Health Services
Clinical and Social Care Governance (CSCG)	A framework within which HSC is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
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 in its provision in the area under review.
POCVA	Acronym for the Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA). POCVA aims to improve existing safeguards for children and vulnerable adults by preventing unsuitable people working with them in paid or voluntary positions.
Risk-Assessment	The identification and analysis of risks relevant to the achievement of objectives.