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**Working Towards
Effective Adult Protection**

**CAWT Development Project
Protection of Vulnerable (Learning Disabled) Adults
Reference Number 17147**

**‘Lessons for the Learning.’
An Exploration of the Lessons to be Learnt from
Service Failure Investigations Relating to Abuse**

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This document was produced as part of stage 2 of the project following agreement of the project outputs, with the Project Board.

The report has been checked and approved by the project's Quality Assurance Team on 9th November 2006, and was circulated to the members of the Project Board on 7th December 2006.

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date _____

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Introduction

Since the scandal arising from the allegations of abuse at Ely Special Hospital in Wales during the 1960's, health and social care services have striven to investigate and eliminate any identified poor practice. There were two outcome foci for this effort, that of reducing the potential of damage to the patients/clients of statutory services, and to ensure the positive reputation for statutory care services and the professionals they employ.

Such investigations have covered a range of services catering for clients of all ages, and have secured the development of a range of systems intended to eliminate, or at least maximise the reduction of, events that would be of major concern to the public. This has included high levels of legislation, regulation and professional codes of conduct/practice.

It could, therefore, be assumed that the likelihood of scandalous and serious events occurring would be rare in services where such increased safeguards underpin performance, delivery and accountability. This does not appear to be the case. Indeed, recent events in learning disability services in Cornwall, and elderly services in the Dublin area have highlighted the fact that major errors are still being made, in what are considered to be professional services.

A paper written by Kieran Walshe in 2002, described the design, use and impact of inquiries within the U.K. N.H.S. sector. It identifies the purpose of such enquiries to be:

1. The establishment of facts
2. Therapeutic exposure to support reconciliation
3. Identification of accountability, blame and retribution
4. The enablement of learning from events
5. Reassurance and re-building of public confidence
6. Identification of issues requiring political consideration

The events contained in, and publication of, inquiries may go a long way to achieve the first three purposes identified, but failure to achieve the 4th purpose will eventually have devastating affects on the achievement of the final two. It is this author's belief that consistent failure in taking advantage of the learning opportunities presented from inquiries is the main causal factor in repeated serious service failure incidents.

This report explores the issues discovered in a range of service investigations relating to allegations of abuse that have been published within the past decade. The intention is to alert services and personnel to the environments that permitted practices where allegations of abuse were produced, and to enable closer service examination in the hope that issues can be locally identified and effectively managed to ensure greater safety for the client group supported.

Context

As the project is concerned with the mechanisms used to support the protection of learning disabled adults from abuse, it has a vested interest in examining available inquiry reports to assist with identifying weaknesses in practice and systems. The identification of such issues should assist with assessment of practice and processes in the partner organisations, highlighting any similarities in both strengths and weaknesses. This can then be used as a mechanism for developing informative learning frameworks and the sharing of best practice information. A N.H.S. project carried out by *Peter Boyland*, '*Sexual misconduct in the health care professions. A breach of trust*', indicates that GPs, psychiatrists, clinical psychologists and community psychiatric nurses are at most risk of being accused, or found guilty of, sexual abuse due to the clinical context of their work. It is essential that services have risk management in place that minimises the potential for this to occur.

This information will be of benefit to service personnel at all levels, and may even assist in the development of internal service assessment tools. The use of this report to encourage constructive discussion between service commissioners and providers regarding positive practice and systems as part of identifying services of quality may begin to bare fruit in safeguarding individuals who are susceptible to abuse.

Process

A set of reports from inquiries carried out by the Health Care Commission (formally the Commission for Health Improvement) is available on its website. These inquiries were instigated at the request of the Secretary of State for Health, North & Mid Bedfordshire Community Health Council and Greater Manchester Strategic Health Authority.

Additionally there was a recent set of events requiring HSE North and the National Director of Primary, Community & Continuing Care in the Irish Republic to commission a review of events surrounding a series of deaths in a private nursing home.

The author examined each of the resultant reports to identify factors that appear to have contributed to environments where clients were exposed to, and were the victims of, practice and systems that can be described as creating institutional abuse.

The reports that were examined were:

- Investigation into the North Lakeland Trust Nov 2000
- Investigation into issues arising from the case of Loughborough GP Peter Green Aug 2001
- Learning disability services - Bedford and Luton Community NHS Trust April 2003
- Investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust Sept 2003

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- Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust July 2006
- Lees Cross review Nov 2006

The findings have been grouped into subject clusters to assist with learning. Where suggestions of practice and system improvement are provided within any of the reports, these have also been identified to support the consideration of potential solution development within services.

Findings from the reports

Key themes are repeated throughout the findings across the reports. In at least two of them, reference is made to a cluster of indicators that can be found in failing service as described in *'Anatomy of a Disaster', a paper produced by Angela Peddar in 2000*. In the paper she indicates that failing services have common indicators:

- Geographical isolation (real or perceived)
- Poor and institutionalised environment
- An inward looking culture with low level governance
- Closed and weak management culture
- Low level staff development with poor supervision
- High dependence on bank and agency staffing support

Such issues were evident in each of the inquiry reports, from both single and multiple site services. The interconnectivity of the resultant influences developed by each of these issues, is crucial in understanding the levels to which an environment that is either supportive of, or non-reactive to, abuse can develop. At very few points within any of the enquiries was there an indication that a single individual led to the issues that required such serious action. If systems fail, then others within the environment become caught up in the catalogue of behaviours and errors that create devastation for those dependent on service support.

Here the findings are grouped by subject matter clusters, demonstrating the range of problems arising across the range of services in the reports. The client groups who were subject to the resultant abuse were older people with mental health problems, adults with learning disabilities and young adult male patients of a GP practice. The involved services ranged from a single GP practice to an elder mental health ward, to 3 Trust-wide specialist support services involving in-patients, assessment units, day care, registered homes and supported living units. This is evidence that settings cannot be predictors of poor environments, in fact some of the settings were in 'modernised' services. Similarly, the abuse was committed by a range of service personnel, both highly experienced and respected professionals, and inexperienced staff with no formal qualification, therefore ignorance cannot be cited as the main factor.

| Culture and philosophy of care | Indicated by |
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| Values and attitudes | <p>Lack of vision and overall strategy that is responsive to client based needs</p> <p>Failure to develop service values in consultation with all stakeholders</p> <p>No opportunities for staff to exchange practice with colleagues in other services</p> <p>Resistance to provide effective channels for users to influence service decision making</p> <p>Little effort to involve users in selection of staff</p> <p>Culture of secrecy and collusion</p> <p>Resistance to receive comments or complaints</p> <p>Persistent denial of problems</p> <p>Little evidence of person centred approaches to service delivery</p> <p>Areas of obvious resistance to change</p> |
| Respect for clients | <p>Staff patronising, bullying, verbal and emotional abuse including swearing, rough handling and demonstration of an uncaring attitude</p> <p>Client facilities sub-standard compared to those provided for staff</p> <p>Clients viewed as secondary to staff</p> <p>Services responding to staff needs in conflict with client needs</p> <p>Clients not viewed as individuals</p> <p>Ignoring concerns and complaints raised by clients</p> <p>Culture of control and punishment was the norm</p> <p>It appears that certain staff viewed the clients as a nuisance</p> <p>Negative reputations regarding certain clients encouraged a lack of belief regarding their claims</p> <p>Some staff held the keys to individual bedrooms and dictated when they could be accessed</p> <p>In some service elements there were areas that were 'out of bounds' to service users without any justification</p> |
| Recognition of how to support client need | <p>No relationship between theory of appropriate practice and actual application to the care of clients</p> <p>Services expecting staff to be able to</p> |

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| | <p>respond to all needs within client group</p> <p>Lack of grade and skill mix to effectively support client needs</p> <p>No stimulation for clients</p> <p>Client care plans not followed due to staffing levels</p> <p>No consideration of how to engage other networks to support client preferences</p> <p>Lack of understanding re how to response to client raised concerns</p> <p>Poor levels of consultation with family carers</p> <p>Resistant to the involvement of external professionals</p> <p>Environment not conducive to maximising client independence</p> <p>Support was not person centred</p> <p>Total absence of, or out-dated care plans</p> |
| <p>Understanding re responsibilities for clients</p> | <p>Failure of visiting practitioners to alert re the standards of practice and affects on clients</p> <p>Services not allocating key staff for clients</p> <p>Poor management understanding of codes of practice relating to staff</p> <p>Staff failing to protect clients from regular risks and harm</p> <p>There was evidence that services used the caring nature of staff to permit the development of risky blurred boundaries that put both clients and staff at risk</p> <p>Some services employed staff prior to full clearance, and then put them on duty in isolation</p> <p>There is serious evidence of clients being left unsupported following traumatic events and investigation</p> <p>Staff and management decided that physical assault was 'part of the territory' amongst the client group</p> |

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| <p>Resentment between staff</p> | <p>Staff feeling it was unfair for them to be required to monitor the practice of poor performers they did not manage Unwelcoming attitude to visiting practitioners Unwillingness to support the interventions of other practitioners There were sections of the service that genuinely felt undervalued amongst their peers</p> |
| <p>Lack of challenge internally</p> | <p>Belief that senior staff were not to be challenged or questioned Failure to challenge staff with professional qualifications Acceptance of professional opinion without question Absence of whistle blowing policies Opportunities for team discussion and consultation were not provided Evidence that some senior staff and managers ruled by a culture of dictation and fear</p> |
| <p>Awareness of what constitutes good practice</p> | <p>Poor practice was the norm and new, junior or inexperienced staff did not realise that it was unacceptable No evidence of advice being sought from other services/professionals No indication of staff training or development Lack of information systems and practice key messages Managers in some areas of service completely failed to ensure induction for new staff Where restraint was used it was not in agreement with assessment and prescription Evidence that some staff and managers were not aware of national guidance and professional codes</p> |

| Management and leadership | Indicated by |
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| Management skills | <p>Services did not take advantage of opportunities to develop staff as potential leaders</p> <p>Many managers were lead clinicians but with no clinical responsibilities</p> <p>No supportive management development programme</p> <p>Lack of effective management appraisal</p> <p>Most managers came from internal recruitment so there was a lack of a fresh perspective on the service</p> <p>Obvious absence of management practice standards</p> <p>Managers unskilled in managing organisational change and team development</p> <p>Often managers were acting in isolation or with outdated information</p> |
| Investigation into concerns | <p>Previous incidences of abuse ignored or dealt with only under disciplinary procedures</p> <p>Lack of clarity regarding appropriateness of identified investigator</p> <p>Sometimes investigations were omitted as the involved manager avoided them</p> <p>Poor feedback to teams that would assist improving practice</p> <p>Sometimes several procedures were used to investigate one issue, causing confusion and duplication</p> <p>Investigations done in secret and without informing next of kin or advocate</p> <p>Some investigations appeared to be looking to identify scapegoats rather than being clear about the causal factors</p> <p>Notes and recordings relating to previous investigations could not be located</p> <p>Obvious absence of a protection policy and procedure</p> |
| Approaches to deliver prevention | <p>No clear plans for action following investigations</p> <p>Lack of involvement of consultation in developing solutions</p> <p>Poor monitoring of responsive action plans</p> <p>Restrictive practices became the norm</p> |

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| | <p>due to fear of incidents</p> <p>Some responses included the exclusion of clients from service rather than addressing the core issue</p> <p>Involved staff were transferred to areas of service seen as punishment areas</p> <p>Strategies were not communicated effectively and so failed</p> <p>It appears that corrective action was taken against the staff whilst the managers were not held to account</p> |
| Approachability | <p>Management did not lend itself to take clinical advice or opinion</p> <p>Excluding staff from decision making and service development</p> <p>Poor levels of skills in leadership and team development</p> <p>Some staff worked at times when there was no management cover available</p> <p>Staff did not know who to report to when they were concerned about their managers actions</p> <p>Board members appeared as aloof and with identified 'favourites' within service areas</p> |
| Management support for whistleblowers | <p>Managers disciplining or victimising staff who had informed of the poor practice of colleagues</p> <p>No identified key contacts for staff needing to use the policy</p> <p>Managers were not always clear about the policy and its mechanisms</p> <p>Staff were not confident that they would be protected if they informed</p> <p>Mis-interpretations caused poor communication of the policy</p> <p>There was a lack of co-operation between management and staff representation regarding the policy and its mechanisms</p> |

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| <p>Multi-purpose service</p> | <p>Poor management ability to operationally consider the requirements for catering for a complex mix of clients</p> <p>Staff had insufficient skills and knowledge for the range of clients they supported</p> <p>Mixed need lead to the use of restrictive practices based on the lowest common denominator of need</p> <p>Confusion amongst staff regarding service priorities</p> <p>Poor management information failed to support effective staffing</p> <p>Problems with funding encouraged managers to seek other financial sources by over-extending their services</p> |
| <p>Supervision</p> | <p>Poor structures guiding supervision</p> <p>Lack of practice standards to guide staff and instruct management</p> <p>Absence of practice audit to inform supervision</p> <p>Poor or no access for night, bank and agency staff</p> <p>Misunderstanding of difference between operational and practice supervision</p> <p>Non-practice focused managers attempting to address practice supervision for professionals</p> <p>Absence of a supervision policy and structure meant that some staff never had supervision</p> <p>Where staff had additional roles, managers did not have the required skills to assess their capacity or capability for the task</p> <p>There were several changes of manager within a short time-frame</p> |
| <p>Staff responsibilities</p> | <p>Managers allocating responsibilities to staff beyond their grade</p> <p>Inadequate management cover to support staff</p> <p>Staff and clients exposed to unacceptable risk</p> <p>New staff placed in positions of responsibility without training or supervision</p> <p>Grading and skill mix structure inadequate to support requirements</p> |

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| | <p>New senior staff were not able to stake their seniority in the service, leaving practice and routines being dictated by junior or unqualified staff of long standing</p> <p>Senior staff spent more time in the office than with the staff and clients, so they were unaware of the level of practice</p> <p>Some staff could not differentiate their own responsibilities from other grades</p> |
| <p>Management visibility</p> | <p>Management appeared to take no interest in certain sections of the service</p> <p>Some staff had never met their line, or senior manager</p> <p>It was obvious that some managers had not visited their dispersed services sites for a long time</p> <p>There were some service areas where managers left everything to the control of staff without question</p> <p>Staff described managers as disinterested and noticeable by their absence</p> |

| Service relationships | Indicated by |
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| Internally focused | <p>Little evidence of positive relationship or communication between the service and external stakeholders</p> <p>There appeared to be no influence from national strategies or recommendations</p> <p>Staff and managers were not encouraged to visit other areas of practice or services</p> <p>The development of plans did not take external factors into account</p> <p>Staff saw external criticism as an opinion to be ignored</p> |
| Public communication | <p>Little public access to board meetings</p> <p>Failure to publish information regarding allegations, investigations and service reviews</p> <p>Contacts set up for public access were often not available</p> <p>Service information was in complex and jargonistic language</p> <p>Public involvement in service audit and examination was not considered or invited</p> |
| Staff/management relationship | <p>Low level consultation with staff and their representatives</p> <p>Excluding staff representatives from discussions relating to practice improvement and working conditions</p> <p>There were claims of management being both unavailable and unapproachable</p> <p>Evidence that the Trust ignored particular areas of service</p> <p>Staff of varying nationalities polarised within the service</p> <p>Non nationals used their first language with each other when on duty</p> |
| Public information | <p>Published material out of date and failing to meet plain language criteria</p> <p>Lack of effort to present information in a range of formats to suit the identified client groups</p> <p>People found it difficult to know what information was and should be available to them</p> <p>The service website was out of date and named people rather than posts as points of contact</p> |

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| <p>Understanding of roles outside of the organisation</p> | <p>Fear and resentment of advocacy services representing clients and families Staff and managers unaware of the responsibilities held by external agencies Staff unaware of external services that could offer support to clients Poor organisational information of the interlinking relationships and responsibilities Professional bodies were not used in an advisory capacity</p> |
| <p>Dominance of hierarchical culture</p> | <p>Belief that senior staff were not to be challenged or questioned Junior staff not encouraged to communicate with upper levels of management Members of the Board not taking an interest in the operational issues of services Confusion regarding the roles and responsibilities of the non-executive board members Professional opinion always took precedence over the experience and knowledge of unqualified care staff</p> |

| Processes and systems | Indicated by |
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| Understanding of relationship between staffing and client need | <p>Personnel dictating staffing levels and skill mix without reference to clinical advice and knowledge</p> <p>Managers expecting staff to perform tasks outside their grade or skill</p> <p>Staff were expected to cater for client needs that arose</p> <p>Commissioning not appropriately relating levels of need to service costing</p> <p>Inability of service managers in developing business plans that are realistic</p> <p>Client assessments were very out of date and did not reflect the current needs</p> |
| Levels of accountability within systems | <p>Failure to set or meet response timescales, or identify key personnel within systems accessed by stakeholders</p> <p>Lack of clarity regarding levels of action that can be legitimately taken</p> <p>Confusion as to various stages of responsibility</p> <p>No evidence to indicate that key systems were reviewed externally</p> <p>Lack of direct consequence for non co-operation</p> <p>No understood agreement regarding seeking permission to use PRN or restraint interventions</p> <p>No identified responsibility for ensuring that paperwork and recording systems were current, understood and used correctly</p> |

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| <p>Recognition of risk factors</p> | <p>Lack of risk assessment and management framework connected to client issues Client risks assessment not included in overall risk management system and review Poor understanding of how capacity, choice and risk interlink Medication systems not effective in ensuring safety and freedom from abuse Personal risk plans not negotiated with client or multi-disciplinary input</p> |
| <p>Staff development</p> | <p>Inadequate system for identifying and prioritising staff training and education needs in relation to clients and service development Poor planning to cater for staff development Services still using 'old fashioned' methods No access to e-learning or research web sites There was no identification of targeted training Unqualified staff often had to forgo training whilst professional staff accessed regular amounts The manager cancelled planned training as staff did not attend and would not engage Poor planning led to staff frequently being prevented from attending training due to lack of cover</p> |
| <p>Internal and external communications</p> | <p>No evidence of an effective communication strategy Staff feeling that they were left out of the communication loop Poor access to electronic information for many staff No development of an Intranet system to inform and advise staff Key service documents not distributed electronically or located on a centralised electronic system Slow public responses to concerns or potential scandals etc. Service seen as aloof due to style of public responses</p> |

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| | <p>Not obvious who should be contacted regarding issues</p> <p>Service website not maintained</p> <p>Key contact information listed by name of staff/manager rather than by post title</p> |
| Monitoring systems | <p>Difficulty with identifying deeply hidden abuse when only using occasional monitoring visits</p> <p>No means of setting, monitoring and benchmarking uniform standards across the service</p> <p>No recording of informal or anonymous complaints</p> <p>Data collection not centralised</p> <p>Information systems mainly paper based and not uniform</p> <p>Inspections often rushed and reliant on reported information rather than observation and enquiry</p> <p>Staff unaware of the systems their work informed</p> <p>Late and under reporting was common</p> |
| Systems to support a learning culture | <p>No mechanism for dissemination of key points resulting from complaints, disciplinaries, and other investigations</p> <p>No internal benchmarking to identify areas for improvement, or locals of best practice</p> <p>Services did not make effective use of internal knowledge and skill to assist with developing staff</p> <p>Internal training is often not appropriate to meet the needs of specialist services</p> <p>There was a significant lack of strategic structure relating to staff development</p> <p>Services show a heavy reliance on theory based training without developing the practice competences of staff</p> <p>A noticeable absence in client input to staff training</p> <p>There was a clear resistance to use a common induction system</p> <p>Some services were unaware of the</p> |

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| | responsibilities to provide staff training |
| Appropriateness of policies and procedures | <p>Policies out of date</p> <p>Lack of clarity within policies and procedures</p> <p>Development of local procedures in response to absence of service wide guidance</p> <p>Policies did not have review dates</p> <p>Although there were policy folders, staff were not aware of them and managers did not refer to them for advice</p> <p>A policy was devised as a response to the issue and staff signed up to it, but there was a failure to monitor compliance</p> <p>Assumptions were made that staff understood policies and their implications</p> |
| Planning and service development | <p>No clear vision or strategy to guide service delivery and development</p> <p>Poor contractual arrangements regarding service capacity and permission for deviations in contract</p> <p>Commissioning not based on appropriate data and information</p> <p>Poor use of assessment information in relation to workforce development</p> <p>A clear lack of consideration for future priorities and how they would be afforded</p> <p>A framework for shared planning did not exist and this led to resentment</p> <p>Comments from external bodies and inspections were viewed as antagonistic</p> <p>It was obvious that they had failed to use criticism constructively to enable Change</p> <p>The development of grade/skill mix was not consulted on or explained and so was seen as a cost saving exercise and undermining of professional roles</p> |

| Staff knowledge and skills | Indicated by |
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| Lack of transfer of learning | <p>No relationship between theory of appropriate practice and actual application to the care of clients</p> <p>Evidence of competence based assessment of practice being undervalued</p> <p>Poor level of opportunities for practice development use in examining skill levels</p> <p>Staff sometimes attending generalised training that could not be assimilated in the specific service</p> <p>There was a lack of interchange of practice between similar services</p> <p>New staff sometimes brought inappropriate practice from other care services with them and were not informed of the need to change</p> <p>Staff skills were underdeveloped in key client support areas</p> <p>Some facilities in services were not used due to lack of staff skills</p> |
| Poor understanding of client safety issues | <p>Staff not trained in risk assessment and management</p> <p>Confusion between client choice and risk management</p> <p>Client risks assessment not included in overall risk management system and review</p> <p>Continued use of the medical model prevented the development of client choice and independence</p> <p>Staff and managers mis-understand the concept of the social model</p> <p>Genuine staff concern for the clients created an environment of over protection</p> <p>The damaging consequences of displayed challenging behaviour were seen as acceptable for the client and staff group</p> <p>Some services engaged staff and agency support without ensuring that checks had been made re their</p> |

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| | <p>suitability for work with vulnerable people</p> <p>Regular occasions when staff were not given time for effective hand over</p> |
| Learning out of date | <p>Practice not guided by research or appropriate learning</p> <p>Practice not governed by current accepted standards</p> <p>Staff not trained regarding the specific needs of the client group</p> <p>Practice not based on evidence or client preference</p> <p>Difficulties in freeing staff to attend training and development</p> <p>Conflicting priorities for staff development due to professional requirements</p> <p>Poor availability of appropriate learning to support client needs</p> <p>No recognition of the changes in theory, philosophy and practice that have been developed in response to knowledge and the modernisation of care</p> <p>Poor relationship with professional educational establishments</p> <p>Client assessments and staff skills did not match</p> <p>Changes in client condition was not responded to in how care was delivered</p> <p>Staff appeared to be unaware of best practice guidance provided by professional bodies</p> <p>Inadequate refresher training</p> |
| Inadequate support for policies and procedures | <p>No evidence of strategies to support the implementation of policies and procedures</p> <p>Key personnel not trained regarding their role in policies and procedures</p> <p>Those responsible for writing policies were either removed from operational services or did not understand how to write such a document</p> <p>Data feedback relating to policies and procedure was not used to improve them</p> <p>Poor quality of leadership was common</p> <p>It appeared to be acceptable for certain</p> |

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| | <p>service managers to ignore wider policies and procedures, and dictate their own versions</p> <p>Senior management failed to check on policy dissemination and interpretation</p> |
| <p>Systems to inform the service</p> | <p>No data collection from complaints, other investigations, or audit to identify and assist learning requirements</p> <p>Ad-hoc or absent staff appraisal system</p> <p>Absent, or ineffective, evaluation systems to inform learning and development</p> <p>There was a reluctance to invite external evaluation of practice</p> <p>Managers and key staff were not trained in using standardised service evaluation tools</p> <p>Members of the board often did not know what information needed to be presented to them regarding workforce development</p> <p>Team meetings were omitted as a vehicle for exploring staff development</p> <p>Where professional bodies had given guidance regarding learning and development, it was not considered</p> <p>Absence of learning and development strategy identifying target staff</p> <p>Individual managers were not expected to report learning activity levels for their service area</p> <p>Structures only reported on professional staff learning</p> |

| Service design | Indicated by |
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| Multifaceted service | <p>Complex mix of client need supported by single staff team</p> <p>Mixed service provision on single site</p> <p>Service users had to ‘put up with’ a range of other people occupying a ‘spare’ bedroom in their home every week</p> <p>The assessment unit had become a permanent place of residence for clients who were difficult to place</p> <p>Environments were unable to support all client needs</p> <p>Staff never certain which clients they were supporting</p> <p>Some services elements were required to register for regulation and inspection but failed to do so</p> <p>Staff were regularly moved between the various areas of service due to staff shortages</p> <p>Clients were ‘congregated’ due to poor staffing levels</p> <p>Environments compromised client safety and self direction due to mixed need</p> |
| Segregated provision | <p>Specialism discouraging knowledge of the client group’s need amongst generic service providers</p> <p>Client group isolated from other members of the community</p> <p>Staff feeling isolated from colleagues in other service provision</p> <p>Generic services did not understand how to support client’s visiting them</p> <p>Some services were physically and geographically distanced, leading to isolation</p> <p>Staff believed that they were expected to cater for clients that ‘no-one else wanted’</p> <p>Evidence that where other services had attempted to engage with clients, staff acted as barriers in the belief that only specialist support would be of any use</p> <p>In some cases health needs had been neglected due to the inability to resource access to appropriate</p> |

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| <p>Competing client/service priorities</p> | <p>Staff feeling that they worked in the 'Cinderella' part of a wider service</p> <p>Budget alterations made at distance without consultation with local managers and staff</p> <p>Service user care plans were not always respected when reviewing service budgets</p> <p>The most challenging clients attracted staff time and resources, leaving the 'quiet ones' unattended</p> <p>Where there were planned closures, budgets were downsized resulting in problems with maintaining environments</p> |
| <p>Set service delivery</p> | <p>Service being offered in a set manner without considering individual client needs or preferences</p> <p>Service user's plans were not met when staff levels were low</p> <p>Often clients had to participate in activities they had not chosen, or did not like, due to staffing levels</p> <p>There was little evidence that the service had attempted to explore extended networks to support the service users in their pleasure pursuits</p> <p>Client interests were catered for in the service, preventing access to regular community facilities</p> <p>Client activity outside the building was dictated by the availability of staff who could drive</p> <p>Service budgets did not cater for staff supporting external activities listed in individual care plans, thus clients had to bear the cost of having staff support</p> <p>Service environments were clinical in appearance</p> <p>Some sections of service used systems that removed any level of client choice or preference</p> <p>It seems that the phrase 'homely' was considered a luxury in comparison to effective budget management</p> <p>There were some managers who did not equip themselves with sufficient and appropriate information to inform discussions regarding service delivery</p> |

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| | and development |
| Evaluation | <p>There was a serious lack of effort in engaging with clients and their families for their opinions</p> <p>The Community Health Council visited regularly and raised concerns but these were only addressed at a surface level</p> <p>Complaints were not used as a mechanism to inform service change</p> <p>Board members were unaware of the number of internal investigations within their services</p> <p>Strategies did not exist to enable changes to be developed as a result of information</p> <p>It was obvious that the service did not have a mechanism for self evaluation and reflective learning</p> <p>The area of service was 'left behind' when the rest of the service modernised</p> <p>Managers chose the level of information they shared with seniors</p> <p>Records relating to self assessment and external evaluation were not used as information tools</p> <p>There was no evidence that the possibility of benchmarking with similar services had been considered</p> <p>Evidence of a clear failure to use national guidance to evaluate the service</p> <p>A grave absence of external monitoring and regulation</p> |

| Governance | Indicated by |
|---------------------------------------|---|
| Service and practice standards | <p>Absence of agreed standards</p> <p>Poor identification of client needs</p> <p>Lack of, or poor risk assessment and management</p> <p>No policy regarding clinical practice and management</p> <p>Lack of consultation re practice standards</p> <p>Recording was ad-hoc at best</p> <p>Client files were variable in quality, and some were non-existent</p> <p>Recording charts were unstructured and some had a range of formats</p> <p>Professions kept separate files and there was a reliance on individual practitioner willingness to share information</p> <p>Repeat prescriptions were often written on behalf of the responsible medic</p> <p>Signatures and dates were often omitted</p> <p>Responsibility for risk assessment levels was unclear</p> <p>Key policies were ineffective and unclear to both staff and managers</p> <p>Some professional staff were in breach of professional codes of practice</p> <p>A clear absence of protocols to guide shared working</p> <p>An absence of even basic risk management practice regarding the storage and monitoring of medication</p> <p>No attention paid to the requirements for client consent</p> <p>Cases where staff did not have the ability to record effectively with the written word</p> |
| Informative framework | <p>Poor communication to support the development of information</p> <p>No interconnectivity between systems</p> <p>No recognition of the value to be added by service user involvement in audit</p> <p>No mechanism for seeking out external opinion</p> <p>Information returns were often missing or out of date</p> <p>There appeared to be no connection between collated information and the</p> |

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| | <p>resultant reports or developments</p> <p>Many staff were unaware for the reason for data collection and felt that it was a wasted exercise</p> <p>Policies and the understanding of confidentiality were absent</p> <p>Regulation requirements from external watchdogs were ignored</p> |
| <p>Environment</p> | <p>The service tended to be secretive about its failings and thus did not connect with the information system</p> <p>Staff were too rushed and overloaded to consider their part in governance</p> <p>Managers did not communicate the importance of governance</p> <p>Some levels of personnel were given portfolios of responsibility that were too large for them to achieve</p> <p>There was an opinion that other service areas that failed to comply with governance, did not suffer a consequence as a result</p> <p>It was apparent that staff and managers within the service did not recognise the links between governance and national/service targets</p> <p>Medications stored in unlocked cabinets and inappropriate places</p> <p>Equipment poorly stored and maintained, often broken and staff not trained in its use</p> <p>Poor quality environments, not meeting hygiene standards, that added to the negative reputation of the clients</p> |

Reccomended solutions

Each of the explored reports provided a wealth of recommendations for action as a result of their findings. Over the decade covered by the reports, very little change occurred within the recommendations, indicating that the potential solutions should be commonly recognised by services. The main differences in the proposals are linked to legislation and regulation changes that are external to each of the investigated organisations/services. Here the suggested responses that are in the direct control of the involved organisations are listed in the same topic clusters for ease. Those relating to external constructs are omitted as they are changeable according to higher level influences and are not able to be controlled in isolation by services. It is, however, vital that services make themselves fully aware of the range of regulations, professional standards, national priorities and legislative frameworks that influence their operation.

1. Culture & Philosophy of Care:

- Service should actively seek out external views
- Develop a pro-active process for consultation that has genuine openness to ideas, comments and suggestion
- Board level business needs to be mainly in the public domain
- Review corporate values and establish a process that ensures that they underpin all policies and decisions
- Effectively engage staff in service values
- Establish effective systems that feed users' priorities into planning and decision making

2. Management and Leaderships:

- Decisions and policies are informed by a proper understanding of the views of users, carers, staff and other stakeholders
- Ensure an improvement programme that incorporates appropriate practice and management leadership development
- Senior management should include representation of those with knowledge and an interest in the client group care, and access to high level credible information and evidence
- Need to appoint managers who will enable change with new approaches to management
- Clarify the responsibilities of operational and practice supervision and communicate these effectively
- Develop robust mechanisms to support the effective dissemination of key policies, and ensure that they are understood

3. Service Relationships:

- Emphasise respect for all people
- Develop and implement a multi-disciplinary and multi-agency approach
- Develop a proactive communications strategy that makes effective use of the full range of communication mechanisms
- Work in partnership with staff representatives and professional bodies
- Ensure that users, carers and staff feel that comments and complaints are valued

- Create a positive relationship with professional and regulatory agencies, to ensure clarity of knowledge and understanding
 - Develop and display relevant, and updated, public information in formats that meet service user need
- 4. Processes & Systems:**
- Ensure the acknowledgement and protection of whistle blowers
 - Develop systems for staff to raise issues in confidence with identified personnel who have the authority to initiate response
 - Review and re-establish the allocation of responsibility for standards and quality assurance
 - Develop mechanisms that enable effective alerting to repeated or serious concerns
 - Develop information frameworks that require input relating to client assessment and need
 - Assess systems and processes for gaps and alter as required
 - Policies and procedures should have identified key personnel who can give correct interpretation and advice
- 5. Staff Knowledge & Skills:**
- Recognise the differences in perspectives across the range of staff, practitioners and managers
 - Establish appropriate systems for assessing and responding to the learning and development needs of all personnel
 - Review, and establish an effective appraisal system
 - Staff development needs should be informed by knowledge regarding best practice and evidence
 - Identify mandatory service induction that meets needs relevant to the clients being supported
 - Establish mechanisms to assess staff competence in relation to job requirements
- 6. Service Design:**
- Planning must show that a proper balance has been achieved between conflicting organisational priorities
 - Review service and assess that it is 'fit for purpose'
 - Examine service budgets and re-evaluate priorities
 - Services should be reviewed and assessed for registration requirements
 - Establish service user action groups to comment on satisfaction levels
 - Monitor service environments to ensure that they do not compromise the safety or independence of service users
 - Managers should explore service design in other areas to observe potential positive developments
- 7. Governance:**
- There needs to be a clear understanding and commitment to effective corporate management and governance
 - Ensure the development of a quality improvement strategy
 - Ensure effective mechanisms for staff to report poor practice
 - Involve personnel with the appropriate knowledge and skills in practice governance system
 - Develop a framework for effective audit and data reporting
 - Encourage the participation of users in service audit

- Ensure the recording and collation of anonymous complaints and abuse alerts
- Establish clear audit trails for the use of medication
- Use a performance management system to ensure that complaints and abuse alerts are responded to appropriately and to the required standard

Conclusions

The belief that such problems only develop in services with poor management, and in under performing Trusts is dangerous. Some of the services that displayed behaviours leading to serious concern, had previously been cited as good services. It was the failure to understand that services need to be constantly vigilant in their development and management, that assisted the creation of environments of failure. The inherent risks that accompany feelings of 'cosiness' in services soon create an environment of carelessness. Neither can such results be linked to particular client groups, as similar issues relating to the abuse of practice have reared their heads regarding the care of chronically sick children in Birmingham, and pregnant mothers in Dublin.

Inquiries have proven that it takes more than 'bad' people to enable the development of service failure when it comes to abusive practices. Without clear statements of purpose, supported by effective related practice, and an appropriate supportive framework, the potential for services to fall into the trap of permitting institutional abuse is high. Very few of the staff and managers interviewed via the inquiries, were disinterested in the clients they cared for, and were stunned to think that their actions were considered abusive. They believed that they operated in the best interests of vulnerable individuals, and removed unnecessary burdens from them. It is often difficult for service personnel to recognise the potential of institutional abuse that arises from their practice, which is why external advice, input and support is required. Sometimes we just 'cannot see the wood for the trees'. As Professor O'Neill stated in his report, what we can see is evidence of complete systems failure.

Currently services in Northern Ireland are subject to major change under the Review Of Public Administration, and the services in the Republic of Ireland are still settling into the new structures formed under the H.S.E. There are some clear risks within modernisation agendas:

- that established good practice is overlooked in the name of change
- that information relating to previous systems is lost or not assimilated into new formulas
- that investment is directed at ineffective systems and technology
- that reviews of staffing establishments is undertaken in isolation of information regarding client need, service regulation, professional supervision requirements and skill mix
- that required policies and procedures are left 'hanging in the air' with a lack of clarity regarding their substance

- that governance information and checks are not provided to inform services of the standards they are required to meet under new structures
- that services with plans for future closure are left unattended leading to serious deterioration in physical environments and staffing supervision
- that rationalisation of services requires a range of clients with diverse support needs to be brought together under a single service area inappropriately
- that service access criteria change and staff skills are not suited to support the new recipients

Ensuring the presence of an environment that is respectful of all, open, enquiring, reflective, based on partnership and governed by agreed standards will decrease the potential for institutional abuse to occur. Modern medicine encourages self-examination for patients in order for them to be alert to negative changes within their own body. A similar approach is essential for services, so that matters, which are of concern, can be addressed at the earliest possible moment.

We will only know if these repeated lessons are being learnt if, in the next decade we see fewer requirements for inquiries into serious service failure relating to abuse. The complexity of a broad range of systems and practice that have impact on the issue, recognises that there is no simple mechanism for addressing the topic. Here is an ideal opportunity for the services engaged in the CAWT adult protection project to review themselves via a framework that concentrates on attempting to reduce the potential for institutional abuse. The outcome from the lessons is reliant on the willingness to learn.

Glossary

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| Appraisal | A mechanism for the regular assessment of the performance of individual service personnel |
| Audit | The continual evaluation and measurement of practice and performance against identified outcomes and standards, with provision to react effectively to failures |
| Evidence based | A systematic analysis that identifies the effectiveness of practice as outcomes for service recipients |
| Governance | A framework that supports the effective delivery of quality to identified standards and requirements |
| Incident | Something out of the ordinary that has a negative impact on an individual, a particular practice or a service |
| Institutional | The rhythm, routine, practice and management of service delivery that is not responsive to or respectful of the individuals served |
| Performance management | A review process that assesses performance against a set of objectives or targets |
| Risk management | A system that enable the recognition, understanding, assessment, recording, effective agreed control, monitoring and review of risks to individuals and the service as a whole |

References

Investigation into the North Lakeland NHS Trust. Report to the Secretary of State for Health. November 2000 Commission for Health Improvement

Investigation into the issues arising from the case of Loughborough GP Peter Green. August 2001 Commission for Health Improvement

Investigation of learning disability services – Bedfordshire and Luton Community NHS Trust. April 2003 Commission for Health Improvement

Investigations into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust. September 2003. Commission for Health Improvement

Joint Investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust. July 2006 Commission for Social Care Inspection and Healthcare Commission

Leas Cross Review. 10th November 2006. Professor Des O'Neill

'Sexual misconduct in the health care professions. A breach of trust', a project lead by Peter Boyland

'Anatomy of a Disaster', Angela Peddar 2000.

The use and impact of inquiries in the NHS. Kieran Walshe 2002