MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 3RD APRIL 2023 - DAY 31

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THE INQUIRY RESUMED AS FOLLOWS ON MONDAY, 3RD APRIL 2023

CHAIRPERSON: Thank you very much.

MR. DORAN: Good morning, Chair. 09:55

CHAIRPERSON: Good morning.

MR. DORAN: Panel members.

CHAIRPERSON: So this morning we have Mr. McGuicken --

MR. DORAN: Yes, indeed.

CHAIRPERSON: -- from the Department of Health. I think 09:55
this afternoon we have Mr. Aidan Dawson from the PHA.

MR. DORAN: That's correct. I should say we are commencing module 2 of the evidence modules today.

CHAIRPERSON: Yes. Tomorrow we are not sitting in the morning, that witness will be rescheduled, but that we 09:56
are sitting at two o'clock, I think, for Ms. Champion, June Champion of the Belfast Trust?

MR. DORAN: That's right.

CHAIRPERSON: Then on Wednesday we have Dr. Petra Corr of the Northern Health and Social Care Trust. Then 09:56
Wednesday, possibly Wednesday morning if we can get to her in the morning, we've got Ms. Jan McGall of the Southern Health and Social Care Trust, and that will complete this week's work.

09:56

I'll just remind everybody we are being live streamed, so if you don't want to appear on camera, go to room B.

I think we can introduce Mr. McGuicken.

MR. DORAN: Yes, if Mr. McGuicken could be called now, Chair.

Can I just say at the outset, it may be that Mr. McGiucken's evidence will take longer than the evidence of Mr. Dawson. Mr. McGuicken has very kindly agreed to return this afternoon, if necessary, to complete this part of his evidence. It may be that we'll have a little bit of an overspill into the afternoon session. 09:56 09:57

CHAIRPERSON: I'm not surprised at all because he's produced a long statement and, I think, 7,500 or so pages of exhibits. I think we should also say this: My understanding is it's not your proposal to try to deal, obviously, with the whole of the statement today, you're just dealing with this module, which is about the first 20 or so pages? 09:57

MR. DORAN: That's correct.

CHAIRPERSON: All right. Thank you very much.

MR. DORAN: Chair, I've been asked to remind you that the electrics are still intermittent apparently. 09:57

CHAIRPERSON: Oh, are they?

MR. DORAN: Just if everyone could be made aware of that at the outset.

CHAIRPERSON: So if everything goes dark, we'll just take a break. 09:57

MR. DORAN: Yes.

CHAIRPERSON: All right, thank you.

MR. MARK McGUICKEN, HAVING BEEN SWORN, WAS EXAMINED BY MR. DORAN AS FOLLOWS:

CHAIRPERSON: Mr. McGuicken, thank you very much for coming to assist the Inquiry. I have met you very briefly before, in fact.

THE WITNESS: Yes, Chair.

CHAIRPERSON: And met you again very briefly this morning. As you know, you will be there for a little while. If at any stage you need a break, obviously just let me know and we'll pause. 09:58

THE WITNESS: Thank you, Chair.

MR. DORAN: Yes. Good morning, Mr. McGuicken. I'm Sean Doran, Inquiry senior counsel. We met briefly this morning. 09:59

A. Super.

1 Q. Now, you've made a statement on behalf of the Department of Health to assist the Inquiry with the current evidence modules; isn't that correct?

A. I have, Mr. Doran, yeah. 09:59

2 Q. The statement is dated 13th February 2023?

A. It is, yeah.

3 Q. I think you have a copy of the statement and relevant exhibits with you?

A. I have, Mr. Doran. 09:59

CHAIRPERSON: Can you just give us one second? I just make to make sure Caseview is working for both my colleagues. Just give us two minutes to reconnect. Mine actually is working today, I'm normally the one

for whom it doesn't work. (Short pause). We're ready. Thank you very much.

MR. DORAN: Thank you, Chair.

Now, are you content to adopt your statement as the basis of your evidence to the Inquiry? 10:00

A. I am.

4 Q. You've also given us a number of exhibits, I think 174 in total; is that right?

A. It is indeed, yeah. 10:00

5 Q. In fact, the statement and exhibits comprise a total of 7,303 pages?

A. That's right, yeah.

6 Q. Needless to say, we're not going to be going to go through it all, Mr. McGuicken, you'll be glad to hear. 10:00

As you're aware, the Inquiry is dealing with a number of evidence modules at the moment and this is, in fact, the first of three occasions on which you'll be attending; isn't that right? 10:01

A. It is, yeah.

7 Q. Today we're dealing with module 2. Later on, you'll be dealing with evidence in respect of modules 3 and 4.

A. That's correct, yes.

8 Q. I think your evidence is scheduled for Wednesday the 19th and Tuesday the 25th of this month, respectively? 10:01

A. That's correct, yeah.

9 Q. Just looking at the schedule, you've been asked to address specific topics within module 2. If I could

just read those into the record. 2A:

"The budget for Learning Disability and Mental Health Services".

10:01

Then there are four bullet points beneath that heading: Northern Ireland and elsewhere in the UK; children and adults; health care and social care; institutional and hospital provision and community support.

10:01

Then topic 2B is Department of Health Oversight of Learning Disability Services?

A. That's correct.

10 Q. That takes us up, I think, to about paragraph 4.13 on page 20 of the statement. I think there is a little bit of overlap between modules 2 and 3 on policies and procedures, so it may be that we will stray into that territory also today, if that's okay with you? 10:02

A. That's fine, yeah.

11 Q. Obviously if you need to come back on those matters, we can deal with that on one of the later occasions. 10:02

A. Thank you.

12 Q. I'm not going to read the statement in. We do have the facility to show individual pages on screen if need be. I'm going to be showing you some of the exhibits as we move along. 10:02

Now, I said that I'm not going to read your statement in, but I wonder if you, Mr. McGuicken, would yourself

read in paragraphs 1.1 to 1.5? Those paragraphs give details of your qualifications and experience.

A. Will do, yeah.

"I am the Director of Disability and Older People within the Social Services Policy Group at the Department of Health. I have been in this post since September 2021. 10:03

As Director of Disability and Older People, I am a member of the senior management team of the Department of Health. I report directly to the Deputy Secretary heading up the Social Services Policy Group. 10:03

As the Director of Disability and Older People, I am Assistant Secretary and the Department Senior Advisor to the Minister of Health on policy for older people and people with disabilities, with responsibility for developing and reviewing developmental policies which underpin the delivery of health and social care services for older people and people with disabilities. 10:03

I have overall policy responsibility for special educational needs, learning disability, physical and sensory disability, autism, adult safeguarding legislation, gender identity, care homes, domiciliary care, carers, dementia and other forms of adult social care. I also have policy responsibility for Muckamore Abbey Hospital. This role includes oversight of the 10:04

Muckamore Departmental Assurance Group (MDAG) and acting as departmental representative on the Learning Disability Resettlement Oversight Board.

"I have been a civil servant for more than 32 years, working mainly in the Northern Ireland office, the Department of Justice, and the Executive Office. I was appointed to the senior civil service when I took up my current role in the Department of Health in September 2021". 10:04

13 Q. Thank you, Mr. McGuicken. You were relatively recently appointed to your current role of Director of Disability and Older People?

A. I was, yes. September '21. 10:04

CHAIRPERSON: Can I just ask if we are going to do that in the future, if we can give the technical people the paragraph number, then I hope that they'll be able to assist us to put it up on the screen. I think this assists us to follow, and also particularly members of the public who may be watching. 10:05

MR. DORAN: I think the best way to do it is to say the page number actually. We can do that in the future if that assists the technical staff.

CHAIRPERSON: Thank you. 10:05

MR. DORAN: In your role then, you have overall policy responsibility for Muckamore Abbey Hospital?

A. I do, yeah.

14 Q. I just wonder, in the earlier stages of your lengthy

career in the civil service, did you have any roles or responsibilities regarding the Hospital?

A. No, none at all.

15 Q. In paragraph 1.2 you refer to the senior management team at the Department of Health. I'm not asking you to name names but can I ask who else would be on that team, what post holders would be on that team, what size is the team? 10:05

A. The senior management, I'm what they call senior civil servant, so I'm a Grade 5 within the Department of Health. The Department of Health would have around, I think, 35 grade 5s of my equivalent. So, I have responsibilities as listed in paragraph 1.4. Other people would deal with dentistry, with GPs, and different elements within the Department. The Department has a structure, I have included in paragraph -- sorry, exhibit MMcG2 as a governance structure. But as part of the Department of Health, the department has eight groups. I sit within the Social Services Policy Group. 10:06 10:06 10:06

16 Q. Yes.

A. Okay. So there are eight different groups within the Department of Health.

17 Q. Just back to that senior management team then, would there be eight individuals in that team? 10:07

A. There's slightly more than eight because there are eight roles. But you would have in addition, in the top management group of the department, you would have the grade 3s, which is the grade above me, the Deputy

Secretary grade, you would have eight grade 3s. You would also have the Permanent Secretary; you would have the Chief Social Work Officer, the Chief Nursing Officer and others within that top management group of the Department. The top management group would sit above the grade 5 category of staff. 10:07

18 Q. So maybe about 15 people approximately?

A. There or thereabouts.

19 Q. In paragraph 1.4 you set out the various areas for which you have policy responsibility. You mention two specific groups or bodies the Inquiry will be hearing more about in due course, that is the Muckamore Departmental Assurance Group, MDAG, and also the Learning Disability Resettlement Oversight Board? 10:07

A. Yeah. 10:07

20 Q. Just by way of introduction, can you outline the roles and responsibilities of those two groups and the role that you play in them?

A. Okay. Well, MDAG is reference to paragraph 4.12, which is at page 19 of the statement. But by way of an overview, MDAG, the Muckamore Departmental Assurance Group, was set up around April 2019 or thereabouts -- sorry, August 2019. It came out of an RQIA report into the hospital, which was critical. There was a suggestion in the letter that came to the Department after that review, or that inspection, that the hospital should potentially go into direct measures, and there was a number of other criticisms in the RQIA report as an outworking of that. 10:08 10:08

21 Q. Sorry to interrupt. Is it the Way to Go report that you are referring to?
A. No, it's not. I will come to it, I'll get the exact title.
22 Q. Yes. 10:08
A. It was a report from RQIA. One of the outworkings of that was the Department then established the Muckamore Departmental Assurance Group, MDAG, okay, and that first met in August 2019. The membership of MDAG includes a number of areas within the Department. It 10:09
has all five Trusts are represented on it, RQIA, the Patient Client Council; Queen's University are also on that group; Mencap; Cedar Foundation; PHA; the British Psychologists Society, and most importantly there are a number of family representatives on MDAG as well. 10:09

MDAG is really to ensure that the Department is assured of the safety at Muckamore Abbey Hospital. It's also to deliver some of the commitments made by the Permanent Secretary in terms of the resettlement at 10:09
that time, and also to support the staff in Muckamore Abbey Hospital in the job they're doing at present.
23 Q. And it's still running, isn't it?
A. It's still running. It met monthly up until Covid happened and it was suspended slightly over Covid, and 10:09
it now meets every second month. It's still going today.
24 Q. I think I'm right in saying that the minutes of the meetings appear on the website; isn't that right?

A. They are published on the Departmental website. Once they are agreed with the members and the families, they are then published on the Department's website.

25 Q. We'll return to MDAG later. What about the Resettlement Oversight Board? 10:10

A. The Resettlement Oversight Board was a recommendation. The SPPG -- sorry, the Health and Social Care Board, or the SPPG as they're now called, the Strategic Planning Performance Group within the Department, commissioned were review by a number of external experts. Ian 10:10 Sutherland and Bria Mongan prepared a report on the Learning Disability Resettlement, the review of learning disability resettlement. One of the 25 recommendations coming from that report - the report was published in July 2022 and again it's on the 10:10 Department's website, and we can provide a copy to the Inquiry if that would be helpful. I'm not sure that we have, because it was slightly outside the terms of reference, but we can --

26 Q. I think the Inquiry does have a copy. That's a 10:10 relatively recent established body?

A. It is, yes. So the Learning Disability Resettlement Oversight Board then is tasked with actually delivering the resettlement of the remaining, as it was at that stage, 36 patients who still have to be resettled from 10:11 Muckamore. So, we meet on a fortnightly basis. The Department asked Dr. Patricia Donnelly to come in and chair that group. So, Patricia would chair that group. Again there's representatives from all the Trusts. PHA

are represented on it, SPPG are represented on it, and I sit as the Department's rep. It is about managing the resettlements of the remaining patients who are still within the hospital.

27 Q. Mr. McGuicken, I wonder could I ask you just to speak slightly more slowly for the assistance of the stenographer. 10:11

CHAIRPERSON: I was going to say that as well. When you talk about it being outside the terms of reference, you are talking about in terms of timing? 10:11

A. Time scale, Chairman.

MR. DORAN: But obviously the issues raised were very much a matter of concern within the terms of reference?

A. Absolutely.

CHAIRPERSON: Yes. 10:11

MR. DORAN: Now, you enter the caveat in your statement that you won't be able to speak through personal experience of many of the matters that you're giving evidence in relation to; isn't that correct?

A. Yes, Sean, yeah. 10:12

28 Q. Nonetheless, the statement is based on a thorough review of the Department's documentary materials; isn't that right?

A. It is, yeah.

29 Q. Just as a matter of interest, how long would a senior civil servant typically spend in your post? 10:12

A. It depends. There's no set 'you must last three years or five years'. In my history of, or my experience of, civil service, we've gone through a number of

iterations around people will stay in a post for three years and then they'll will move on, or people will stay somewhere for five or six years. My own history and career history has been that I've stayed in posts for largely six or seven years and then moved on.

30 Q. Yes.

A. My predecessor, I think, was in post for two and a half/three years, and similarly to his predecessor before that in this current role. It's a particularly commanding role, as I've read out in paragraph 1.4. So, I have been in post now around 18/19 months. But there's no set you will do two years in a post and move on, it really is very dependant on the individual circumstances of each post and the person in the post.

31 Q. But presumably if the Inquiry wanted to speak to any of your predecessors about matters that occurred during the period of the terms of reference, they could easily be located?

A. They could, yes.

32 Q. And they could provide answers if you can't provide them?

A. Absolutely.

33 Q. Just before I get into some of the details in the statement, you provide a diagram in your first exhibit. That's at page 90, if that could be brought up on screen, please. Just as a matter of interest, was that diagram prepared for your statement or was it taken from some other source?

A. It was prepared for my statement.

34 Q. Thank you. It's helpful in that it shows where the hospital fits within the Department's organisational structure. Sometimes, of course, the apparent simplicity of a flow chart can be deceptive. You may not thank me for this but I wonder if you could possibly talk us through the various levels and explain to us where you fit into the picture? 10:14

A. Okay. It's not coming up on my screen so I will go for the hard copy, if that's okay?

CHAIRPERSON: Certainly do, but also just turn that screen on. Is it possible to minimise this document slightly so we can get the whole thing on screen? 10:14

MR. DORAN: That's it. The hospital is now fully on screen.

CHAIRPERSON: That's it. 10:15

MR. DORAN: So you have got MAH at the bottom and the Minister for Health at the top.

CHAIRPERSON: It's always the one screen that matters that you can't make work. Are you all right to refer to it and we move on? 10:15

A. I can work off the hard copy.

MR. DORAN: The witness has a hard copy, Chair. In fact, I think you have a hard copy of all the exhibits for today's evidence; isn't that correct?

A. I do, Mr. Doran, that's correct. 10:15

The diagram, I suppose, shows the overall structure going from the Minister down through the Permanent Secretary. You know, this specific diagram would show

the sponsorship arrangements for Muckamore Abbey as an acute hospital, okay.

Now, I mentioned at the start around having eight different policy groups within the Department. If you go from the Minister of Health, the Permanent Secretary, I suppose the Permanent Secretary, Department of Health, and the sponsor department should be in brackets as opposed to it being the full title. 10:16

The Health Care Policy Group then, I mentioned that I sit within the Social Services Policy Group. The Health Care Policy Group and Social Services Policy Group are two of those eight wider policy groups within the Department. It shows you off to the right-hand side there as well about the Resource Corporate Management Group Deputy Secretary. So, if we were to give a full explanation of the Department, you would have a page with eight different groups across the top. 10:16

35 Q. Yes, I see. 10:16

A. In terms of the direct responsibility, if you like in terms of Muckamore, the Trust's sponsorship, which is the box below the Health Care Policy Group, is a sponsorship across the board for all Trusts, and then flowing from that, a sponsorship of Belfast Trust. 10:17 Then Muckamore Abbey Hospital would sit below that as an acute hospital.

36 Q. Just for the lay person, can you explain what sponsorship means in this context?

A. Sponsorship. I come to sponsorship in terms of Managing Public Money NI, which is a document we produce as well later in my statement. But sponsorship is really around holding to account. Part of it will be around ensuring that they're delivering against Departmental objectives, delivering against the ministerial objectives and pay and rations, if you like, in terms of some of the budgetary aspects as well. So, that is the role of sponsorship.

37 Q. So accountability mechanism? 10:17

A. Roughly, yes.

CHAIRPERSON: So if we were to put a name into that box now, would that be SPPG?

A. No. SPPG sits slightly to the right-hand side of that. In terms of this diagram for a governance structure, it would be the Health Care Policy Group, which is one of the eight policy groups within the Department. 10:17

CHAIRPERSON: Right.

A. SPPG are slightly aside to that in terms of the actual budgetary responsibility. In terms of policy responsibility, it's the Health Care Policy Group would sit there. 10:18

CHAIRPERSON: But that sits above the sponsorship branch. Who would be the sponsorship branch?

A. The sponsorship branch would be a group headed by someone at my grade within the Department. There is a specific sponsorship branch underneath that Health Care Policy Group, and you would have a number of different branches within that sponsorship branch dealing with 10:18

different aspects of Trusts and other issues they dealt with.

DR. MAXWELL: So you say sponsorship branch as there's more than one sponsor?

A. It probably should say sponsorship branches. 10:18

CHAIRPERSON: Yes, thank you.

MR. DORAN: Just off to the left there, there is a reference to SPPG, in the box to the left.

A. Yes. So that's where I would fit in, because the arrow going back up to that and towards the top hand level says: 10:19

"Sponsorship of Belfast Health and Social Care Trust have responsibility of the Department of Health as a whole. Financial matters are dealt with DOH, SPPG. Financial and policy matters are led by the respective policy leads." 10:19

So when it comes into the policy for Muckamore Abbey Hospital, that's where I would start to fit into that and again that's where the Social Services Policy Group, the wider policy group, would fit into that role. 10:19

38 Q. So within that box to the left, you essentially represent the DoH? 10:19

A. Yes, in terms of policy.

39 Q. And there's a direct connection then. You're the kind of link, I suppose, between the Permanent Secretary and the Trust?

A. In terms of policy, yes, but not in terms of operational aspects of it.

40 Q. Yes.

A. If I could give an example which might help, Mr. Doran. In terms of the proposed closure of the hospital, the consultation on the closure of the hospital, that would have been my responsibility to advise the Minister and the Permanent Secretary on those issues and to develop that consultation, whereas the operational aspects of it and the financial aspects of it are more the SPPG side of things. 10:19 10:20

41 Q. Yes. Now that we're on SPPG, is it correct to say that SPPG is actually housed within the Department?

A. It is, it's part of the Department. Now, the terms and conditions of SPPG staff are managed through the Business Services Organisation because they have slightly different terms and conditions. But for all intents and purposes, they are part of the Department of Health. 10:20

42 Q. That is because of their previous status presumably? 10:20

A. It was, yes.

DR. MAXWELL: Can I ask, though, the HSCB was an arm's length body?

A. This was yes.

DR. MAXWELL: And SPPG is not an arm's length body? 10:20

A. No.

DR. MAXWELL: So it's not the same status?

A. No, it's integral to the Department.

MR. DORAN: The SPPG is essentially the successor to --

A. To HSE.

43 Q. -- the board, but is of quite a different character in that it is integral to the Department?

A. It is integral. The majority of functions would be similar to what the board delivered. But you're right to say their legal standing, if you like, they're different. 10:21

MR. DORAN: And we will hear from an SPPG witness in due course.

10:21

Now, in paragraphs 2.9 to 2.33, Mr. McGuicken, you provide a sketch of the policy and legislative landscape. I'm not going to delve into all of the details in those paragraphs in oral evidence but I just want to ask about some salient matters. 10:21

A. Okay.

44 Q. Correct me if I'm wrong, but it is fair to say that there are three critical levels at which health care services in this jurisdiction are managed. You have the Departmental level, the board level and the Trust level? 10:22

A. That would be correct.

45 Q. And the third tier, the Trusts, was essentially a creation of the 1990s?

A. Yes. 10:22

46 Q. So, prior to the formation of the Trusts, both the commissioning of services and the delivery of health and social care services would have been a matter for the regional Health and Social Care Boards?

A. That's my understanding.

47 Q. But following the creation of the Trusts, the boards assumed the primary role in commissioning services whereas the Trusts had the role of delivering services?

A. Again that's my understanding. 10:22

48 Q. The boards also had additional responsibility for performance management, service improvement and resource management?

A. (Witness Nods).

49 Q. Now, keeping an eye on the terms of reference, as we always have to do, it seems to me there are a few key dates or milestones at each of those levels that you flag up in your statement. First of all, going way back to 2000, the body that the Department had created called the HPSS Management Executive, which used to 10:22 10:23 oversee the performance of the Trusts, was discontinued in 2000 when the Northern Ireland Executive was formed; is that correct?

A. That's my understanding.

50 Q. Essentially its functions were absorbed within the Department? 10:23

A. Yes.

51 Q. So that's a change at departmental level, if you like, back in 2000?

A. Yes, it would be. 10:23

52 Q. Then in 2007, one had the reduction from 18 Trusts to six Trusts?

A. Six Trusts.

53 Q. The six Trusts include the Ambulance Service, of

course?

A. Yeah.

54 Q. So that's a change at Trust level?

A. Yes.

55 Q. In 2007? 10:24

A. Yeah.

56 Q. Then in 2009 there was a reduction from the four health and social services boards down to one central health and social care board?

A. That's correct. 10:24

57 Q. So that's a change then at board level --

A. Yeah.

58 Q. -- within the period of the terms of reference?

DR. MAXWELL: Can I just clarify? In 2000 when the HPSS Management Executive was discontinued, didn't the 10:24 responsibilities go to the HSE Board and not the Department?

A. Well, I've stated at paragraph 2.25 that when the management executive was discontinued - sorry, page 89 - when the management executive was discontinued with 10:24 the creation of the Executive, its functions were absorbed within the traditional structures of the Department. That's my understanding. I wasn't there at the time but that is my understanding of the relationship at that stage and how it was absorbed. 10:25

DR. MAXWELL: Okay.

MR. DORAN: That's something we can return to in due course if it transpires that the information is --

DR. MAXWELL: I just think it's important because the

whole principle was about separation of political and management responsibilities, and that's quite significant. So, I think we will need to clarify at some point.

A. I can come back on that. 10:25

MR. DORAN: It's certainly something we can explore again in due course.

Then last year, obviously, as you've already mentioned, the functions of the board were transferred to SPPG? 10:25

A. Yeah.

59 Q. Which now lies within the Department itself?

A. Yes.

60 Q. I suppose, in theory at least, the structure today is a simpler one than it was 20 years ago? 10:25

A. I would suggest it is a simpler one, yeah.

61 Q. You had the Department and Management Executive, four area boards and 18 Trusts, and now you have the Department, SPPG, which is within the Department, and six Trusts? 10:26

A. Six Trusts, yeah.

62 Q. I just wanted to ask you about something that you say at - now this relates to SPPG, I should say. You've already mentioned that the staff of SPPG were originally staff of the board; isn't that right? 10:26

A. Yeah.

63 Q. Essentially those individuals who worked for the board are now continuing in what is a somewhat different capacity within the Department?

A. I'm not sure how many of the staff who are currently within SPPG were formerly board staff. I know the majority of the staff transferred over. There's been new staff brought in since April last year, so they wouldn't all be the same staff who are delivering. By and large all the staff there at the time transferred over to SPPG, is my understanding.

64 Q. Just looking at what you say at paragraph 2.33. This can be brought up on screen. It's at page 8. It's the final paragraph on page 8, where you say: 10:26 10:27

"The closure of the HSCB was an important initial first step in changing the landscape in which health and social care services operate. It has provided the health and social care system with an opportunity to transform how it plans, manages and delivers services in line with the vision set out in Health and Wellbeing 2026 - Delivering Together that I have included at MMcG5." 10:27

I'm not going to go to the exhibit. Without getting into the details of that report, can you explain in lay terms how SPPG will operate differently from its predecessor, the board?

A. I'm not over the full detail of that, Mr. Doran, if I'm honest with you. My perception would be that it was suggested that commissioning was maybe not as effective as it should have been under the board structures, and to bring SPPG more closely into the Department and an 10:28

integral part of the Department would allow those structures to flow, just to flow better, if you like.

The role, bringing SPPG into the Department, I suppose brings it all into one family, so you have no separation between commissioning and oversight because it's all within the one body, whereas before the Department would have asked -- or the board would have given direction to the board, the board would have then commissioned it from the Trusts, whereas now it's all within one structure in the Department. 10:28

So, the grade 3 within SPPG is part of that formal top management group within the Department, so there's a lot more synergies between policy and commissioning and delivery. 10:29

65 Q. Would it be fair to say that the improvement of commissioning was the key objective of the reform?

A. That is something which, to put on record for me, would be difficult to say, Mr. Doran, because I wasn't there at the time. But my experience of having worked there in the last 20 months, I find the relationship between my policy area and SPPG colleagues to be very, very strong and we work together very, very well in terms of how the impact of policy will impact on the delivery of services on the ground. 10:29 10:29

66 Q. Do you agree that, as a general proposition, it's the Department itself that's ultimately responsible for the quality of care delivered by the services that SPPG

commissions?

A. As one entity, as one structure within the Department, yes, I would agree with that.

67 Q. So overall --

A. Yeah. 10:29

68 Q. -- the Department of Health has responsibility?

A. Yes.

69 Q. Now, just to move on to deal with the specific evidence module topics that you've covered in your statement, and I've already flagged up the four subtopics. First 10:30 of all, you refer to the position in Northern Ireland and elsewhere in the United Kingdom. You begin by pointing out the basic difference between Northern Ireland and the remainder of the United Kingdom as regards the allocation of funding. 10:30

I wonder if page 9 of the statement could be brought up on screen, please? I'm going to read in paragraph 3.2. There you say:

10:30

"Northern Ireland, uniquely in the UK, operates an integrated model of health and social care provision whereby HSC Trusts are responsible for providing both health and social care services in their areas of operation. This contrasts with the position in 10:31 England, Scotland and Wales where the provision of social services remains the responsibility of local authorities."

So, there's a basic organisational difference between this jurisdiction and elsewhere?

A. Yes, there is. I would say it's more than basic, I would say it's pretty fundamental, Mr. Doran.

70 Q. Yes. You make the point then that it's difficult to make meaningful comparisons on the expenditure between the two different models? 10:31

A. Yes.

71 Q. You also say that the Department doesn't hold information for Learning Disability Services in other jurisdictions? 10:31

A. No, that's accurate. We don't hold that as a comparison with other jurisdictions in GB.

72 Q. I know the Department has explained that to the Inquiry and there have been some exchanges about that because obviously that information will be of interest to the Inquiry. But I just wonder why such information isn't held? Would it not make sense to ensure that there are ongoing comparisons that can be made between this and the other jurisdictions, for your own purposes going forward? 10:31 10:32

A. I think it's just you're never making a straight comparison, because if you were comparing the budgets being spent or how much was being spent in GB, you would not be looking at the totality of spend. So, for example, if you're looking at what NHS England spent on health care, you wouldn't be comparing what Northern Ireland spend on health and social care, because the two things are totally separate in GB. 10:32

Where we need to find detail, we can go and find that detail. Within the time scale of producing the report, it wasn't possible for us to get that level of detail between what is spent here and what is spent elsewhere in GB. Now, there are some of the reports within the evidence pack which do provide some comparisons, but again they're caveated within that to say that it's not comparing like with like between here and GB.

73 Q. Now, you say you can't make comparisons but is it fair to say that you regard the Northern Ireland model as having its advantages? 10:33

A. I've only ever worked in the Northern Ireland model so that's the model I know. But I would suggest giving health and social care within one family of delivery is far more -- it's a better model than having the two things separated. 10:33

CHAIRPERSON: To make a comparison with GB, you would need to know, presumably, what every local authority spends -- 10:33

A. You would, Chair.

CHAIRPERSON: -- on social services?

A. Social services, yeah. Yeah. That's why it remains particularly difficult to do that, Chair. If it was the same model we deliver here, it would be very simple to go to the Department of Health and Social Care colleagues in England and say what do you spend on learning disability? 10:33

CHAIRPERSON: No, I understand.

A. But the separate local authority makes it difficult.

DR. MAXWELL: Can I ask you your comment? You felt that integrating health and social care is better. Is there any about evidence of that? Have there been any evaluations? 10:34

A. There may well be. I was saying in my experience over the last 20 odd months I have found it to be having that integration is very, very important, because you're not stopping one service at a hospital door, that service carries on into the community in terms of 10:34 domiciliary care.

DR. MAXWELL: But there is no data comparing that with the rest of GB?

A. I am not aware of it. But we can look into that and if there is anything, we will provide it to the Inquiry. 10:34

MR. DORAN: I'm not going to look, in broad terms, at how the budget in this jurisdiction works, that would take us well beyond the terms of reference. I do want to ask you about a couple of other things in this part of your statement. 10:35

First of all, at 3.8 you note that spending on health and social care at the macro level equates to about 45% of the budget; is that correct?

A. That would be correct. Actually, it's probably closer 10:35 to 50% of the budget as we currently sit, Mr. Doran.

74 Q. Now, I just want to pick up then on what you say at paragraph 3.10. That's on page 10, if that could be brought up on screen, please. In paragraph 3.10 - it

runs into the following page - you say:

"The Department does not allocate funding on a patient by patient basis. It determines its priorities and then, given the funds available, budgets against those funds and allocates resources for the HSC Board or more recently SPPG, so that, in conjunction with the Health and Social Care Trusts, the needs of individual patients, clients, carers and families can be met." 10:35 10:36

Can I just ask, generally speaking, how does the Department determine the priorities, as you put it?

A. Well, the priorities are determined in relation to programmes of care. I go on to talk about programmes of care quite extensively. 10:36

75 Q. And we'll look at those in a moment.

A. Yeah. It's not that we would allocate funding on a per capita basis. We wouldn't say the Department would allocate X amount of pounds per population of Northern Ireland to deliver services in specific, you know, programmes of care. We give the money, whatever money comes from the Executive, and that process is an iterative process in terms of how much comes to health and how much comes to other departments. We would then allocate that in terms of to the HSCB, to SPPG as it is now, and the programmes of care which would then be developed through the capitation formula, which again I explain as best I can in my statement. 10:36 10:36

76 Q. I'm just wondering though, who, if anyone, would be

responsible for putting the case for increased funding for Mental Health or Learning Disability Services, or is that how things work?

A. Well, in terms of putting the case, it would be for the Minister to put the case to the Executive for additional funding as part of the Northern Ireland block. Obviously, those conversations happen at Executive level when we have an Executive sitting. Currently those conversations are more challenging, but it's done at Permanent Secretary level at -- 10:37

77 Q. Just, Mr. McGuicken, can I ask you to slow down again?

A. Sorry. Apologies.

78 Q. I think the stenographer may find it difficult to get everything recorded.

A. As I said, those conversations happen at a high level, at Executive level, and in negotiations then with Treasury. Once the budget is then set, the Department would then take direction from the Minister to say what ministerial priorities would be, and they would then flow down into what is delivered at Trust level by the board. 10:38

79 Q. I suppose just picking up on the question again, who would be putting the case to the Minister for increased allocation for Learning Disability/Mental Health?

A. That would be largely my responsibility and through the SPPG, through my deputy secretary at SPPG. Sorry, SSPG, apologies. SPPG and SSPG, because I am Social Services Policy Group. 10:38

80 Q. Okay.

A. Those conversations would happen at our top management group. Part of the role of the top management group would be to set the priorities within the Department, which would then flow down into what is delivered on the ground.

81 Q. I think we'll have to be careful with those two acronyms?

A. We will. Sorry, Chair.

82 Q. I keep harking back to the terms of reference, but paragraph 17 of the terms of reference reads: 10:38

"The Inquiry will consider the adequacy of financial resources to ensure: A. Appropriate numbers, skills, quality and training of staff. B. Appropriate care, treatment and accomodation for patients with mental health conditions and/or learning disabilities treated or cared for at Muckamore Abbey Hospital." 10:39

Just considering that paragraph in the terms of reference, how would describe the Department's responsibility for funding decisions that bear on individual facilities like the Muckamore Abbey Hospital? 10:39

A. I think to put it in context, I explained at the start in paragraph 1.4 of my areas of responsibility when you look at the spend against those areas, it comes in at about 1.6/1.7 billion per year. When you look at the overall budget for the Northern Ireland block sitting at around 13 billion a year, you know, I think you can 10:39

show that when you're spending that amount of money from a totality of 13 billion on learning disabilities and mental health, it does show that the importance that the Department puts on those areas.

10:40

I am not aware, in my time in post, of sort of the Trusts coming to us saying we need more money. Now, part of the resettlement programme which I mentioned, the work being taken by the Resettlement Oversight Board does look at how much each individual 10:40 resettlement will cost, and then part of my role is developing how we then find the money for that, because that is additional money.

To answer your question directly, I believe there is 10:40 sufficient resource being allocated within a very, very tight financial climate that we currently are in terms of Learning Disability and Mental Health. If we had more money, we could do more and we could spend more money. I believe that, given the restraints we 10:40 currently have, that level of funding going into those areas is significant.

83 Q. But ultimately, funding decisions relating to individual facilities like the Hospital are a responsibility of the Department? 10:41

A. Well, they flow down, as I say. The model would be that the overall budget is set; SPPG would then differentiate that into programmes of care. Those programmes of care are then delivered through Trusts on

the ground. When you take it through -- I do not have responsibility or policy responsibility for how much an individual Trust will spend on a specific area of health care or an individual hospital, but as an overall system, yes, we have responsibility for how much is spend at individual levels in Trusts.

84 Q. But first level funding decisions would be a matter for the Trusts?

A. The Trusts, yeah.

DR. MAXWELL: Can I just ask who advises you on - sorry, if you were going to get to this - who advises you on what level of funding is required for minimum standards?

A. I don't get into that level of detail around what would be required for minimum standards. The minimum standards would be something which would need to be -- is a Trust issue, and there are standards that the Trust would need to say whether the money they have allows them to deliver a minimum standard.

Mr. Doran touched briefly on MDAG, and one of the roles of MDAG is to look at staffing levels within Muckamore Abbey Hospital. Part of those conversations within MDAG and the conversations I would have with Belfast Trust would be around staffing levels and safe staffing levels. But that's specific to that element of MDAG.

DR. MAXWELL: I was thinking more widely. I was thinking would the Public Health Agency be advising you, for example?

A. Not advising me directly because I don't have a role in looking at safe staffing levels within individual hospitals, I'm more at that policy level. There are lines of, if you like -- there are certain things which I am responsible for, there are other things which SPPG and Trusts are responsible for. So, not being a clinician, I wouldn't get into that level of detail around safe staffing, actually.

MR. DORAN: Now, at paragraphs 3.12 to 3.14 you describe the process whereby these annual commissioning plan directions are issued. Those are formal directions issued by the Permanent Secretary under statutory powers; isn't that right? 10:42 10:43

A. They are, yeah.

85 Q. I think the governing legislation is the Health and Social Care (Reform) (Northern Ireland) Act 2009? 10:43

A. It is.

86 Q. You exhibit the plans from 2009 to 2020 from Exhibits 6 to 17. I'm not going to ask about those documents. It's fair to describe them, I think, as high level aspirational statements about the delivery of health and social care services that are commissioned on an annual basis? 10:43

A. Yeah, they would set the high level direction for delivery. 10:44

87 Q. Again, you then, which you've already mentioned, you go into the capitation formula --

A. (Witness Nods).

88 Q. -- and programmes of care, beginning at paragraph 3.17.

Again, I'm not going to delve into all of the details but I do want to pick up on a few points. At paragraph 3.17 you talk about the prediction of need across five local commissioning group population areas. Now, can I just ask, do those five local group population areas correspond with the areas for which each of the Trusts are responsible?

A. That's my understanding, Mr. Doran, yeah.

89 Q. You then go on to refer to the nine programmes of care that, as you put it, are used to plan and monitor the health service? 10:44

A. Yes.

90 Q. Am I right in saying that those programmes of care are, in fact, specific to Northern Ireland? This too a different model from that used in England and Wales? 10:45

A. That's my understanding.

91 Q. And does this particular model date from 2008?

A. I think the model laid out at page 470 is still the one we're using today.

92 Q. And that's from 2008, I think? 10:45

A. Yes, it is. There had been a number of changes in terminology, and the document sets that out. There's some terminology which would have been relevant in 2008 would not be appropriate to be used today.

93 Q. Yes. But basically -- 10:45

A. The programmes of care have remained the same. Remained constant, yeah.

94 Q. In paragraph 3.24; that's on page 14, if we could have that on screen, please. I just wanted to ask you about

a specific point here.

A. Okay.

95 Q. You say that the expenditure within Programme of Care 6 - and Programme of Care 6 relates to learning disability; isn't that right? 10:46

A. It does, yeah.

96 Q. You say:

"POC 6 relates to expenditure within Trusts on services for people with a learning disability and includes all 10:46 activity and resources used by any health professional where the consultant in charge of the patient is a specialist in Learning Disability. In addition, this programme includes all community contacts where the primary reason for the contact was due to an 10:46 individual's learning disability".

Now, when you say that the expenditure includes resources where the specialist in charge is an expert in learning disability, does that include expenditure 10:46 on allied health professionals, for example, dietitians, physiotherapists, other therapists?

A. That is my understanding. The information we get is against that programme of care, so that would be how the Trust would allocate or categorise the expenditure. 10:47 My understanding is, as I've said there, it's any interaction with someone with a learning disability would be categorised under that programme of care.

There are some services which overlap between different specialties and at times you maybe don't get it down to the exact pounds and pence of what has been spent, but, as I said, that's a definition for the programme of care and that's how Trusts will then report their expenditure.

97 Q. Would that also include, for example, social care, day services, residential staff, respite?

A. That's my understanding, yes.

98 Q. You say that learning disability is the third largest programme of health and social care expenditure, at 8%? 10:47

A. It is.

99 Q. I think later in your statement at paragraph 3.31 you say that POC 5, mental health, is the fourth largest at around 7%? 10:48

A. Yes. That's based on the actual expenditure returns from Trusts.

100 Q. Yes. Now, just before I move on from the programmes of care, 5 and 6 seem to be fairly discrete; you've got learning disability on the one hand and mental health on the other? 10:48

A. Yep.

101 Q. Last week in evidence, we heard from Professor McClelland. One point that he made about the progression of resettlement is that one finds that people with the most complex needs remain in the hospital for the longest, and these are people with a learning disability who may, in fact, have serious mental health needs in addition. Do you see where I'm 10:48

going?

A. Yeah, I do.

102 Q. My question is how would this kind of hybrid need service fit in under the Programmes of Care funding?

A. In terms of the resettlement, they would specifically be coming out of the Programme of Care 6 under Learning Disability, because it's within the definition of that that they would be seen by a clinician with a learning disability specialism. That would be coming under this programme of care. 10:49

103 Q. In terms of hospital, when the patient is in hospital?

A. It depends where they are -- how they are brought into the hospital. There is a lot of cross-over between some disability and mental health issues, as you will be aware. In terms of the actual expenditure, I think it would depend on which ward they were admitted to if they do come into hospital. But I don't have that level of detail, my apologies. 10:49

104 Q. That's something perhaps we can pursue with --

A. Yeah. 10:50

105 Q. -- another witness. Now, you go on then in your statement to deal with the issue of children and adults and expenditure on children and adults. In paragraph 3.26, if that could be brought up on screen, please, you refer to the global spend on Learning Disability Services, and you point out that that rose from 240 million in 2010/2011 to 412 million in 2018/20. 10:50

A. Yes.

106 Q. Again, that equates to around 8.6% of the total health

budget?

A. Yes.

107 Q. Looking at those figures, the 240 in 2010/11 to the 412 in 2018/20, can you say if that represented a proportionate increase in real terms or was it simply an increase in the expenditure total in line with everything else in the area of health and social care? 10:51

A. If I could maybe turn to page 502, Mr. Doran, because that detail would be slighter better in...

108 Q. We can bring that up on screen, please. That is one of your spread sheets or tables? 10:51

A. Yeah. That shows the actual expenditure across each Trust from the years, it starts at 2008/2009 -- actually, it starts earlier than that at 2003/2004 across the page. It shows then the level of spend sort of each year increasing as we go along. 10:51

What I would say is that in 2010/2011, the 240 million equated to around 7.7% of total expenditure. It has increased on a slow trajectory from there at 7.7% to the 8% that we have today. 10:52

109 Q. So there is a proportionate increase --

A. There is a proportionate increase.

110 Q. -- spending on Learning Disabilities Services?

A. It is always around the 7.7 to 8.6%. It is increasing slowly as the overall budget. As a percentage, it has remained relatively constant and increasing slightly year on year. 10:52

111 Q. Yes. Given that proportionate increase then, how come

learning disability was regarded as a special case to merit that increase in funding in proportionate terms?

A. I'm not aware. As I say, I wasn't in the Department at the time so I'm not sure whether it was ever considered as a special case as such, although I am aware that a number of comprehensive spending reviews would have seen significant cuts in other budgets, whereas the learning disability budget did remain pretty standard across, or consistent across, those years. You could read into that that it was made a special case. But I'm simply reflecting your words on that, I don't have the details to say whether it was reflected as a special case or not, or whether it was just that amount of funding wasn't there to continue to deliver that year on year. 10:53

112 Q. But it seems more than an accidental increase, doesn't it?

A. Yes.

113 Q. I mean, it's relatively significant from the 7.9, was that the figure you gave? 10:53

A. 7.7.

114 Q. 7.7, I apologise, to 8.6?

A. 8.6, yeah. In terms of a point seven, point eight percent increase, it doesn't sound significant. But when you balance that against other programmes of care, potentially taking significant percentage cuts, it does seem to be that it has been -- "effective" isn't probably the right word. 10:54

CHAIRPERSON: Forgive me, I didn't mean to interrupt

you. If you just look at those two examples, you have 240 million in 2010/'11, 412 million in 2019/'20, but actually the jump comes not in the hospital but in the personal social services?

A. I think that would reflect, Chair, around the fact that a lot of people had been resettled at that stage. 10:54

CHAIRPERSON: Exactly, yes.

A. So, the resource would not have then needed to be directed towards the hospital.

CHAIRPERSON: Yes, because your hospital costs aren't actually going up very much, are they? 10:54

A. No, but the overall budget expenditure -- not budget, the overall expenditure is going up. My understanding is that it would largely reflect that community care requirement. 10:55

CHAIRPERSON: Yes, thank you.

MR. DORAN: Now, regarding expenditure on Adult and Children Services, you say there's no way of separately identifying the split in the information held?

A. Yeah. 10:55

115 Q. Is it simply impossible to drill into the information the Department has to obtain those figures?

A. My understanding is there is no separation of transition. You have children's services and you have adult services, but some of those services would straddle those transition periods. It would be virtually impossible, is what we've been told, to separate the expenditure on both. 10:55

116 Q. Yes. Now, you go on then to consider the two final

bullet points in topic A together to provide a breakdown of expenditure across all of the settings. We've already been looking at some of the relevant exhibits. The two final bullet points are health care/social care and institutional hospital provision and community support. We've got it on screen at the moment. That's Exhibit 19, which summarises spending reported by the Trusts on Disability Services. Then Exhibit 20 is a similar table reported by the Trusts on Mental Health Services; isn't that correct? 10:56

A. It is.

117 Q. We'll just keep Exhibit 19 on the screen for a moment. I beg your pardon, I'd like to read in actually paragraphs 3.28 to 3.32, just to provide the full context to this information. If we can go then to page 15, please. If you could bear with me for a moment. You say at 3.28: 10:56

"I have taken these two headings together to provide a breakdown of learning disability spend across all these settings. I attach at MMcG19 a spreadsheet summarising POC 6 spending reported by Trusts on providing learning disability services over the period 1999 to 2021, broken down by hospital services, community services and personal social services. Community services relate to health care provided outside of after hospital setting, such as, e.g. district nursing, health visiting and community psychiatric nursing. Personal social services encompass personal care 10:57 10:57

services provided for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care and protection. Therefore, the expenditure listed at 19 may include extended services somewhat outside POC 6, albeit connected to learning disability.

"3.29. POC 5 relates to expenditure on Mental Health Services and includes all activity and resources used by any health professional relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties: Mental illness, child and adolescent psychiatry, forensic psychiatry and psychotherapy. The relevant specialty is determined by the contract of the consultant who has responsibility for the patient.

"3.30. It also includes all activity and resources used by a hospital consultant in one of those specialties in relation to outpatient episodes, day cases, regular day admissions, regular night admissions or day care. In addition, it encompasses all community contacts by any health professional where the primary reason for the contact was due to mental health.

"3.31. POC 5 is the fourth largest programme of HSC expenditure, accounting for around 7% of the total allocation.

"3.32. I attach at Exhibit 20 a spreadsheet summarising POC 5 spending reported by Trusts on providing mental health services over the period 1999 to 2021, broken down by hospital services, community services and personal social services."

So, just going back then to the document that we had on screen at 502, and I just have a number of questions about these two tables or spread sheets that you've provided. First of all, can I ask you was this information compiled specifically for the Inquiry or is it extracted from a pre-existing source?

A. My understanding is it's from a pre-existing source that would be reported by Trusts on a yearly basis.

118 Q. Yes. I think there's a reference somewhere to Trust financial returns?

A. Yes, yeah.

119 Q. Perhaps the table was extracted from each of those returns over the 20-year or so period; is that right?

A. Yes, to provide that coverage for the Inquiry.

120 Q. Just in relation to community services or the community services portion of the expenditure, touching again on an area that I touched on slightly earlier, does that include funding for multidisciplinary teams in the community, day services, and staff costs for community residential care?

A. My understanding is it does but I can clarify that for the Inquiry. I'll get the exact detail of that, Mr. Doran.

DR. MAXWELL: Can I just ask, in Northern Ireland do you separate nursing care costs and social care costs in residential care? In England it would come from two different budgets, whether it was a nursing home or a residential home.

A. I think they come from the one budget within Northern Ireland. But again, I can clarify that.

DR. MAXWELL: Do you think that's community or personal social services?

A. I think that's personal social -- it depends on the setting, is my understanding.

DR. MAXWELL: The residential care is probably coming out of the personal services --

A. Personal social services, yeah.

DR. MAXWELL: -- budget, not the community?

A. Not the community. My understanding is the community budget would be around community care in terms of, if you like -- "managing" is the wrong term, but in terms of meeting the needs of individuals within the community as opposed to that residential or care --

DR. MAXWELL: And when they visit the care homes as well?

A. Yeah.

DR. MAXWELL: But they're not staff of the care homes?

A. That is my understanding. But again, I will come back and clarify the exact detail of that if we have that detail.

MR. DORAN: Just coming back to the table, looking at the Belfast Trust, I think the Chair referred earlier

to the increase in some of the elements other than the hospital figures. But looking at the hospital figure for the Belfast Trust for 2007/2008 through to 2019/'20, the figure seems to remain fairly constant at in or around 30 million for that period. Do you see that?

A. Yes, I do.

121 Q. I suppose, on one view, does that not seem surprising, given the increased emphasis on resettlement?

A. The table actually at paragraph -- or paragraph 506 details expenditure specifically for Muckamore for the three years 2016/2017 --

122 Q. Yes. I'm going to look at that in a moment actually.

A. So I don't think -- in terms of the exact expenditure, there are a lot of costs within the hospital which are, if you like, sunk costs, because they will be there any way because of the infrastructure of the hospital.

123 Q. Yes.

A. There are other costs around staffing. Particularly at the minute the hospital is staffed significantly with agency staff. Around 85% of the staff in Muckamore at this present time are agency staff which are more expensive than Trust staff. A lot of that is to do with the suspensions of staff due to the ongoing police investigation, so a lot of the staff have been brought in from agencies. So it doesn't surprise me, to be honest with you, Mr. Doran, that the costs have stayed significantly high despite the fact we are down to a relatively small number of patients currently within

the hospital setting.

124 Q. So once the hospital remains open, there's a relatively fixed --

A. There is, yeah.

125 Q. -- cost -- 11:03

A. There is.

126 Q. -- that is required to keep it running?

A. There are, yeah.

127 Q. Now, can I ask you then just about the Departmental view on the allocation between the three elements. 11:04 Does the Department have a view on whether the current allocation is the appropriate one?

A. I wouldn't have a view on whether it's the appropriate one. These are based on actual expenditure from the Trust, so it's not that this was the budget that was 11:04 set, this is the expenditure against each element reported by the Trusts in terms of their annual reporting in terms of expenditure. I don't have a specific view whether the expenditure against hospitals, as opposed to community care or personal 11:04 social care, are relevant or, I mean, are appropriate, it's what has been spent.

128 Q. Yes.

A. In my experience in the last 20 months, I can see how the costs for resettlement are significant because of 11:05 the particular challenges for the individuals which we're trying to resettle. There are some significant costs there. There are also significant costs in running an inpatient unit for learning disability and

mental health. I don't have a view as to whether the costs are appropriated basically as what has been spent by the Trusts in delivering that programme of care.

129 Q. My final question in relation to this table relates to the footnote. Can we just scroll down, please? I think it appears on the next page. I think it's a fairly technical point relating to the computation of the figures from 1999 to 2003, and I just wanted to see if you can explain this for the lay person. 11:05

You say that:

"The figures for 1999 to 2003 are not directly comparable with later years as the figures above represent the total expenditure, including adjustment for sub-commissioning spend, whereas later years exclude this area of expenditure." 11:06

A. I'm not able to give an explanation for that, Mr. Doran. That has come from our finance colleagues. But I will get an explanation and provide it to the Inquiry. Apologies. 11:06

130 Q. Thank you.

DR. MAXWELL: Can I ask you what sub-commissioning spend means? 11:06

A. Again, I would have to get that answer. I only wish I could explain it but unfortunately I can't.

DR. MAXWELL: Okay.

MR. DORAN: Chair, I wonder would this be a suitable

moment to have a break?
CHAIRPERSON: Sure, thanks. We have been going for an hour and a quarter, so perfect. So we will take 15 minutes. The secretary will look after you. Okay. Thank you very much. We will try and start again at half past. 11:06

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you very much. 11:26
MR. DORAN: Now, Mr. McGuicken, I'm going to move on to ask you about another table that you referred to earlier, and that's the one that relates specifically to the hospital. I wonder if page 16 could be brought up on screen first, please. At paragraph 3.33, you say: 11:27

"Specifically in relation to the costs associated with running Muckamore Abbey Hospital, in 2019, as part of contingency planning on the future role of the hospital, the Department commissioned the HSCB to carry out an analysis of the budget allocation for commissioning delivery of services at the Muckamore Abbey Hospital site over three years from 2016/2017 to 2018/'19. I attach at Exhibit 21 a spreadsheet which was provided to the Department by the HSCB in response to this request and which details the budget and expenditure on services at the hospital in the three years specified. More up-to-date information is not 11:27 11:27

available at present due to financial returns being unavailable from Belfast Health and Social Care Trust during the COVID-19 pandemic."

Then if the exhibit itself at page 506 could be brought up on screen, please? You refer there to contingency planning on the future role of the hospital. Can you help with the following: What specifically prompted this particular exercise to be conducted? 11:27

A. Again, Mr. Doran, that was before my time, but I understand that was in terms of looking at the future of the hospital, whether the services remain on the Muckamore site or whether, as part of that resettlement programme, once the patients had been resettled, what the future of the actual physical site would be at Muckamore. 11:28 11:28

131 Q. Just looking at the table itself, you'll recall when we looked at the two earlier sets of figures that you provided, there was a running figure of around 30 million annual hospital spend for the Belfast Trust? 11:29

A. Yes.

132 Q. You recall that. How does the 18 million figure in this table square with that 30 million figure in the other tables?

A. I'm just looking back to the figures in 2016/'17. I'm not sure, Mr. Doran, to be totally honest. I'm not sure what the discrepancy is. 11:29

CHAIRPERSON: This is headed "Budget and Costs Muckamore Abbey Hospital". So is this restricted to

the hospital --

MR. DORAN: The hospital itself.

CHAIRPERSON: -- hospital costs?

MR. DORAN: Yeah. I suppose the possibility is that there were other facilities, Belfast facilities, included in the Trust figure. 11:29

A. Sorry, that would have included Iveagh and other facilities. Apologies, yes. The overall hospital cost, my understanding, would include Iveagh and other facilities within the hospital estate. 11:30

133 Q. Yes. So, 18 on Muckamore and the other 12 on other facilities within the Belfast Trust area?

A. Apologies, yes.

134 Q. I think you've covered this point to an extent already, but presumably the fact that there's relatively little change in the overall figure during the three years is attributable to the fixed costs of running the hospital? 11:30

A. There would have been minimal resettlements, is my understanding, over those three years as well. The patient numbers, I understand, were relatively stable across that period of time as well. 11:30

135 Q. From 2016 to 2019?

A. Yeah.

136 Q. Presumably equivalent statistics could be obtained, if need be, for previous years? 11:30

A. I think this was a special exercise looking at those three years. It would take a bit of work but I am sure it could be, yes, for previous years. If the Inquiry

needed that, we could look into that with the Trust.

PROF. MURPHY: Sorry, could I just clarify, the other hospital provision in the Belfast Trust for learning disabilities, Iveagh Centre, is for children. I thought it was quite small. I'm quite surprised it was using 12 million, or whatever the difference is here. 11:31

A. I was making a connection there. We will try and provide more accurate figures for the Inquiry. I was just making the assumption that it was in terms of Iveagh and potentially other facilities that we would be using at the time. We will try and desegregate the figures for the Inquiry, because I think it's important that we do. 11:31

CHAIRPERSON: It might not just be Iveagh?

A. Yes. It may be others as well. 11:31

MR. DORAN: That is something we can obviously pursue with the Trust as well.

I just wanted to ask you about one other matter regarding this table. If we could scroll down on screen, please, to some of the text beneath. Now, there's a paragraph beginning "The staff costs under-spend". It's not easy to read on screen, the type is quite small but I think we can enlarge it a little bit. You may or may not be able to assist with this but let me just read this extract to you in the first instance: 11:32 11:32

"Staff costs under-spend in nursing and midwifery is as

a direct result of the significant recruitment issues that are faced in MAH. This is why decision has been made to pay the 15% recruitment and retention allowance to staff in an effort to retain those currently in post, but also attract additional staff into the site. 11:32
In '18/'19 the full impact of the high agency spend had not yet been felt. Agency spend in '17/'18 was 166,000, in '18/'19 was 2.1 million, and in '19/'20 was 6 million. At current rates, BHSCT expect to see a full year cost of agency for MAH of some 9 million for 11:33
2021, given the position by period 2 has been an average spend of just over 750,000 per month. The agency expenditure is ramped up significantly due to the high volumes of agency numbers needed to cover vacancies, high sickness absences, suspensions, but 11:33
also the premiums which is required to be paid to those staff due to the Trust having to utilise off-contract agencies."

I wonder if you can perhaps explain that from a 11:33
Departmental perspective?

A. In terms of the 15% enhancement, my understanding is that was an enhancement to staff who were working within Muckamore, to basically encourage them to continue to work within the hospital. Actually, we 11:34
have reintroduced it. That enhancement was taken away, I think, during Covid, because a different enhancement was brought in for Covid rates. We have since reintroduced that 15% sort of enhancement to costs for

people working shifts in Muckamore and people coming from other shifts to work in Muckamore, specifically due to the challenges of staffing within the hospital.

DR. MAXWELL: Sorry, is that consolidated or is it a one-off? 11:34

A. It's consolidated. For every shift that someone works in Muckamore, whether they're substantive staff in Muckamore or whether they are coming in to cover a shift from another Trust, they get a 15% enhancement to the hourly rate they would normally get for their band. 11:34

DR. MAXWELL: So that's fully pensionable then?

A. I think it is. But again, we will back with specifics on that. I think it is pensionable.

MR. DORAN: I just note the first sentence there that "staff costs under-spend in nursing and midwifery is as 11:35 a direct result of the significant recruitment issues that are faced in MAH"?

A. Yeah.

137 Q. Now, that under-spend was in existence in 2016/17, isn't that correct, or at least there was a relatively 11:35 significant under-spend in 2016/17?

A. It is, yes. I was trying to get the figures. It was there in 2016/'17, yes.

138 Q. That predates the specific concerns about the hospital that emerged in 2017; isn't that right? 11:35

A. Well, I suppose if you look at the overall figures, the total budget for '16/'17 for nursing and midwifery was 11.9 million, and there was an under-spend of 727,000. It's not significant in terms of a percentage

under-spend against the budget of 11.9 million. So I think, you know, it would be reflective of -- I couldn't work out the percentages in my head, Mr. Doran, but I don't think it is that significant in terms of the under-spend against the budget. It does reflect the fact that there were difficulties in recruitment even at that stage, to my understanding. 11:36

139 Q. That is my point, and that predated the information that emerged --

A. Yes. 11:36

140 Q. -- in 2017 as regards the CCTV footage; isn't that right?

A. That's my understanding. Again, I wasn't there at the time, Mr. Doran.

141 Q. It's something we can explore with other witnesses. But the significant recruitment issue doesn't seem specifically to be tied to the period post 2017; is that correct? 11:36

A. That would be my reading of that as well.

142 Q. Now, the final topic for today's evidence session is the Department of Health's oversight of Learning Disability Services. If we can go back into the body of the statement and go to page 16, please, running on to page 17. At paragraphs 4.1 and 4.2 you mention a number of reviews that have been conducted in the area of health and social services in Northern Ireland; isn't that right? 11:37

A. Yes, Mr. Doran.

143 Q. Just looking at the reviews listed in 4.2, those are

all at the macro level, so to speak?

A. They are, yes.

144 Q. You've exhibited those documents, helpfully, in the statement. Some of them are fairly substantial. I'm not going to bring you to them today as again it would take us well beyond our terms of reference. I do want to look at an important document that emerged from the restructuring of the health and social care system in 2009, and that's the Framework document. Now, you refer in paragraph 4.3 - if we could just scroll down a little bit - you refer to the requirement on the Department to produce a framework document setting out the priorities, objectives and relationships for each health and social care body. The relevant exhibit is Exhibit 31. That's at page 1145, if that could be brought up on screen, please. 11:38 11:38 11:38

Sorry, can I just pause for a moment? I'm going to perhaps read in your summary, Mr. McGuicken, at paragraph 4.5. If we could just scroll down a little bit on screen, paragraph 4.5, where you say: 11:39

"The Framework document sets out how the strategic agenda for the HSC is determined and how priorities and targets are set, monitored, and performance managed. It describes how resources are allocated, monitored and managed and how the system is held to account. The document describes governance processes and the role of independent challenge. It is intended to be a clear, 11:39

high level framework within which the HSC bodies must operate. It is supported by more detailed governance mechanisms, including the management statements and financial memoranda for each HSC organisation, which must be prepared by the Department in line with the Department of Finance requirements. Nothing in the Framework document detracts from the Department's overriding authority and accountability for health and social care. It is important to note, however, that operational delivery of services is provided by Trusts, who are accountable in the first instance to their Trust board with regard to staffing and provision of services at local level. Section 6.33 of the HSC Framework refers..." 11:39 11:40

Now, just when you say there that accountability lies in the first instance with the Trusts to the Trust board, I assume you're not seeking to minimise in any way the overarching responsibilities that the Department has for those matters within this jurisdiction? 11:40

A. No. That's why I've emphasised "in the first instance" there.

145 Q. This document, I think I'm right in saying, is produced as a result of a statutory requirement; isn't that correct? 11:41

A. That's my understanding. It's the (Reform) Act, the Health and Social Care (Reform) Act 2009, that requires us to produce that.

146 Q. Yes, I think it's Section 5 of the Act sets out the requirement. Chair, I wonder if I might just pause questioning of the witness for a moment to introduce this document to the Panel?

CHAIRPERSON: Yes, please. Can you just give us the page number? 11:41

MR. DORAN: The page number, and we have it brought up on screen now, it's 1145. This is the Framework document, as it says on the cover. I'm not going to go through it page by page obviously, Chair, but I wanted to flag it up to the Panel and the Core Participants as being of general assistance to us over the forthcoming weeks. 11:41

Just to home in perhaps on paragraph 1.6, if you could scroll down, please. Paragraph 1.6 lists the health and social care bodies as set out in Section 1.5 of the (Reform) Act. Those bodies are regional health and social care board, known as the health and social care board. We've heard about how those functions are now performed by SPPG. 11:41 11:42

2. Regional agency for public health and social well-being.

3. Regional business service organisation, known as Business Services Organisation. 11:42

If you scroll down, please.

"The HSC Trusts, special agencies, i.e. the Northern

Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency, and Northern Ireland Guardian Ad Litem Agency; Patient and Client Council and Regulation and Quality Improvement Authority." 11:43

So, Chair, one sees that the responsibilities of quite a few of the bodies or organisations that the Inquiry will be looking at are listed within this particular document, which I think requires careful reading. 11:43

If one scrolls down then to paragraph 1.8, please. This relates to the issue of accountability.

"All of the HSC bodies referred to above remain ultimately accountable to the Department for the discharge of the functions set out in their founding legislation. Changes introduced by the (Reform) Act augment but do not detract from that fundamental accountability." 11:43

Again, Mr. McGuicken, that emphasises the fundamental accountability lies with the Department; isn't that right?

A. It does. I agree. 11:44

147 Q. At paragraph 2.1 then there is a flow chart, which may also be of assistance as we move forward.

CHAIRPERSON: Yes.

MR. DORAN: I'm not going to --

CHAIRPERSON: No, I think we all find that very helpful. I certainly have. There is one question I was going to ask, but I'll leave it to you and we'll see if it's covered.

MR. DORAN: Chair, I'm happy enough if you ... 11:44

CHAIRPERSON: It's just this, the role of the BSO. In this flow chart, it seems to directly assist the Department but not have a role in any of the other bodies. Is that really right?

A. I think it's just by way of the actual diagram, Chair. 11:44
My understanding is the BSO would flow up to that top level and they all then flow up into the Department. BSO really does not have any direct engagement with the Department, it's really the pay and rations, if you like, for Trusts and equivalent. 11:45

CHAIRPERSON: Yes, exactly. That's really what I thought. Because this is slightly -- it's slightly misleading in the way this is structured.

A. Yeah.

MR. DORAN: I am not going to go to it but paragraph 11:45
6.61, that is at page 185, reinforces the accountability point that we have covered already.

I'm aware that the legislation in Section 5.3 requires the Department to keep this document under review and 11:45
provides that the Department may, from time to time, revise the Framework document. Can you assist the Inquiry with how that review process works?

A. I'm not aware of when the last review was, Mr. Doran.

I have not been involved in any of the reviews of the government's framework but I'm more than happy to write back to the Inquiry on that. Apologies, I don't know the detail of that.

148 Q. Thank you. You're not aware then of any revisions that may have been made to the document through the years? 11:46

A. No. I would suggest if this is the document we produced, this must be the most up-to-date revision of it. But again, we are happy to clarify that for the Inquiry. 11:46

149 Q. I wonder if we can go back then to page 18, please. Now, I should say in the first instance, the Framework document that we've looked at applies across all health and social care services in Northern Ireland; is that right? 11:46

A. Yes, it does, yeah.

150 Q. In paragraphs 4.7 to 4.13 you go on to describe what you refer to as limited oversight arrangements that have been established specifically within the context of Learning Disability Services. 11:47

A. Okay, I'll maybe just correct that slightly. I have said time-limited as opposed to specifically limited. So, they were time bound as opposed to being limited oversight.

151 Q. So time-limited oversight arrangements. By that you mean they were established for a set period of time? 11:47

A. Yes, or they were established to do a job and then folded down once that role had been either completed or the landscape had changed for something else to take

over from that. There's some references there in terms of the Minister. At my paragraph 4.10, the letter from the Minister around that time to colleagues around standing some of those structures down.

152 Q. Yes, I'm going to come on to look at that. I think there's some overlap here with module 3 on policy and procedure. 11:47

A. Okay, yeah.

153 Q. Are you content if I broach some of these issues now?

A. I will do my best, Mr. Doran, but I had prepared specifically for module 2. I totally accept there is some overlap between this and some of the elements of module 3, so I will endeavour to answer as much as I can. 11:47

154 Q. Just primarily I want to clarify what the various arrangements are and how they work, how they relate to each other and how they relate to the hospital. 11:48

A. Okay.

155 Q. Now, the first two that you mention are specifically Bamford related. In paragraph 4.8 you refer to the inter-departmental ministerial group chaired by the Health Minister that was established in 2007. The purpose of that group was to oversee the Bamford vision for Mental Health and Learning Disability Services. I wonder could you outline for the Panel the composition of that group and how it operates and how often it meets? 11:48 11:48

A. That group no longer meets. I don't have the detail of the make-up at that time. That group was stood down.

As you see at page 1202, it was stood down by the Minister so it no longer meets. That's one of the references to time-limited interventions.

156 Q. Ah, yes.

A. That group met from a point in time and then was stood down. As my understanding, it was one of the recommendations coming out of the review to stand that group down. 11:49

157 Q. We'll come on in a moment just to look at the circumstances of that because one of my questions was going to be has it actually been stood down? Because I know there is a reference in the statement to the intention to stand the group down, but it has actually been stood down; is that right? 11:49

A. It has been. My understanding at the time that would have went to the Executive, the Executive was not in place at that time. The Minister wrote -- the Minister at the time wrote to Executive colleagues basically saying that that group be stood down. Some of that group no longer meets, certainly doesn't meet under my remit, and I don't think it meets at all. 11:49

158 Q. Presumably the minutes of any meetings held by the group would be available?

A. If they are available, we will certainly supply them to the Inquiry. 11:50

159 Q. The second oversight arrangement to which you refer is related to that also and related to the Bamford process. That's the Bamford monitoring group comprising service users and carers that was set up in

2009 and supported by the PCC. I think you refer to that in some detail in paragraph 4.9?

A. Yeah.

160 Q. Isn't that correct?

A. That's correct, yeah. 11:50

161 Q. You say that its purpose was to provide an independent challenge function. When you say "challenge", do you mean challenge to the Department?

A. I would suggest it was challenge to the system as opposed to specifically to the Department. I can only 11:50 reflect on - we'll come to that in a second, I'm sure, Mr. Doran - but I can reflect on it current reference on MDAG. Currently the family representatives we would have on MDAG and patient and client counsel would be challenging to the council, to the Trust, to RQIA. 11:51 It's not simply I think to one particular part of the system, it's a challenge function to the system as a whole is how I would describe it, rather than just to the Department.

11:51

But by extension, the Department has overall responsibility, so therefore if they are challenging any part of the system, they are ultimately challenging the Department as well.

162 Q. Would the purpose have been to give service users and 11:51 the public a voice then in the response to Bamford?

A. That's my understanding of the situation. Certainly that is where we are with MDAG, which is the current sort of oversight arrangements.

163 Q. Now, I just wanted to ask you about the Bamford evaluation report that you mention in your statement at paragraph 4.10. I think this is the report that led to the bodies being stood down; is that correct?

A. Yes, that's my understanding. 11:52

164 Q. You have referred already to the letter from the Minister of Health at the time, and that was Michelle O'Neill at the time; isn't that right?

A. It was, yeah.

165 Q. This document appears at page 1202, if that could be brought up on screen, please. Just let me read in the text of that letter. It's dated 14th December 2016. If we could just scroll up a little bit, please. It's addressed to various ministers from the Minister of Health, who, as I've said, was Michelle O'Neill at the time. The letter reads: 11:52 11:53

"Bamford evaluation. I am pleased to attach the draft Bamford evaluation report for your consideration. The report indicates that much has been achieved to improve services for people with mental health or a learning disability. They also highlight a number of areas where development was required so collectively we could continue to improve the lives of these people within our community. 11:53 11:53

"In terms of the way forward, the report concludes that there is little benefit in creating another Bamford action plan and that the identified needs are included

in the new population-based outcomes focused programme for government.

"With regard to the Bamford structures, the report recognises the important role played by the ministerial group, the interdepartmental senior officials group and the Bamford monitoring group, but recommends that the time has come to stand these structures down and mainstream the continued development of Mental Health and Learning Disability Services. 11:53 11:54

"I would be grateful if you could review the documents and respond by Wednesday, 11 January, on your areas of interest, following filling in any gaps in information which still exist. I will then send the final drafts to the Executive for formal approval." 11:54

If you just scroll down a little bit, please. Then:

"I wish to thank all colleagues and their officials for the valuable contributions to this extensive exercise and for your continued support in making the lives of people with mental health or learning disability better." 11:54

Now, you've already indicated the structures were stood down thereafter.

A. Yes.

166 Q. Isn't that right?

A. Yeah.

167 Q. At one of your later exhibits, that's Exhibit 44, you have exhibited the 2012 evaluation. I wonder was this 2016 evaluation to which you refer, or to which the letter refers, was it ever published? 11:55

A. My understanding is it was never published because it did not receive Executive approval. From memory, the Executive fell around that time and, therefore, there was never Executive approval to publish the second evaluation. 11:55

168 Q. Is the document available?

A. It's available but it remained unpublished.

169 Q. But presumably it can provided to the Inquiry?

A. I think we would have to take legal advice on that, Mr. Doran, given that it was an Executive -- it went to 11:55 the Executive but was never approved by the Executive. If it's possible to provide it, we will certainly provide it.

170 Q. But it seems that this is the document that was instrumental in these particular bodies being stood 11:55 down?

A. Yes. From the Minister's letter, that's correct.

171 Q. I wonder can you explain from the Department's perspective why the view was taken that the Bamford oversight structures, including the interdepartmental 11:56 group, should be wound up at that time?

A. My understanding - and again, not being there at the time - my understanding is that that was the recommendation of the evaluation; that those structures

should be stood down, and the Department, I think, accepted those. The tone of the letter, certainly from the Minister, is that the Department had accepted that recommendation that those structures would be stood down. As I say, I wasn't in the Department at that stage so I can only go from what I've read from this.

172 Q. But to understand the rationale for that decision, one would have to see the document?

A. The Minister would have seen the document and provided that advice to ministerial colleagues. 11:56

173 Q. More broadly, if anyone were seeking to understand the decision, presumably you'd accept that they would have to see that document?

A. It would certainly be helpful to see that document. As I say, we will take advice on that and if we can provide it to the Inquiry, we will provide it to the Inquiry. 11:57

174 Q. I mean, I'm asking this question because at that time, elements of Bamford, such as the resettlement initiative, clearly had not been completed? 11:57

A. Yes, and still has not been completed, as we have...

175 Q. So one can understand why the Inquiry would wish to understand the background to that decision and the rationale for it?

A. Yes. I can totally understand, yeah. 11:57

176 Q. Now, the third oversight arrangement that you mention - and you mention it at paragraph 11 - is the Service Framework Programme Board, isn't that right? You say at paragraph 4.11 - it's back to page 19, please:

"The Service Framework Programme Board which was set up in 2007 was chaired by the Chief Medical Officer, was originally constituted as a subgroup of the Departmental board. In 2015 the redefined terms of reference for the terms of reference for the board noted the members at Departmental policy and professional leads, with the Chief Medical Officer as Chair. This programme board oversaw the governance arrangements for the timely delivery of the service framework programme, including the Service Framework For Learning Disability and the programme board terms of reference that I have included at Exhibits 33 and 34. I provide more detail on the learning disability service framework in modules 3A and 3L." 11:58

Am I right in saying that that body is responsible for service frameworks right across the health and social care system?

A. That's my understanding, Mr. Doran, yeah. 11:59

177 Q. As you've indicated, that includes the service framework for learning disability?

A. Yes.

178 Q. I'm just going to have a look at that document now. It's at page 1204. That's the cover page. Just can I ask you, Mr. McGuicken, for a nonmedical audience, if you like, can you give an explanation as to --

CHAIRPERSON: I think you mean clinical.

MR. DORAN: Sorry, Chair?

CHAIRPERSON: Nonmedical has a specific meaning. You mean clinical?

MR. DORAN: Or I should have said from a lay perspective perhaps.

CHAIRPERSON: That's even better. 11:59

MR. DORAN: Assisting us then, Mr. McGuicken, can you give an explanation of how a service framework actually works in practice?

A. A service framework basically, hopefully in layman's terms, will set an overarching framework of how a 12:00
service should be delivered and the accountability structures for that service. It would be my -- as a brief explanation of a service framework, it would be around setting those structures in place, how they would be accounted for and what they would be expected 12:00
to deliver against.

179 Q. Now, just looking then at the Learning Disability Service Framework, I think this was first introduced in 2015; is that right?

A. That's correct. 12:00

180 Q. It's a very person-centred document, if I can put it like that.

A. Sorry, just to go back on one. As I've noted at 4.11, it was originally put in in 2007. The redefined one we have here was 2015. 12:01

181 Q. Is 2015. So, the Learning Disability Service Framework was first introduced in 2007, but this version, which is the last version --

A. Yeah, yeah, yeah.

182 Q. -- was first introduced in 2015.

As I was going on to ask, it's a very person-centred document. It refers to the interests of or the perspectives of the patients and staff. Can you give the Panel an idea of how that service framework was actually brought into operation? I mean, did it actually result in a change in how organisations were managed, how services were delivered, how staff were trained and organised? What impact did it have on the ground? 12:01 12:01

A. From not being there, it's very difficult to answer what impact it had specifically in terms of making a difference. Certainly, as you say, there are a lot of standards and targets included within this document which I can only assume would have been monitored by the Oversight Board, the programme board, that was there. So, apologies, I don't have the detail to answer the specific question, Mr. Doran.

183 Q. So the programme board would be responsible for oversight? 12:02

A. Yes. Well, I think that's what it says at sort of the defined terms of reference for the programme board. That's at 1362.

184 Q. If we could go to 1362 then, please. 12:02

A. I think at 2.1, which is slightly down the page there, it does say what the overall aim of the service framework was, which probably articulates it better than I tried to do, Mr. Doran, in answer to your

question.

185 Q. That reads:

"The overall aim is to improve the health and wellbeing of the population in Northern Ireland, reduce inequalities and improve the quality of care, recognising that achievement of this aim goes beyond traditional HSC boundaries and is strongly influenced by population individual attitudes and behaviours, and contribution of other sectors." 12:02 12:03

A. Yes. So as I say, it sets out about putting in the service framework, and then the individual targets within that would flow from that overarching...

DR. MAXWELL: Would it be the programme board that is responsible for the changed management? Because you can write a framework, set standards, but if you are trying to change practice, you need to change management programme. Do we assume from this document that the Service Framework Programme Board were responsible for that changed management? 12:03 12:03

A. If we go down to the next page, maybe that might answer your question more because at 3.2 it sets out the remits of the Service Framework Programme Board. That might... 12:03

DR. MAXWELL: It doesn't include the changed management. Where would the changed management responsibility sit then? This is about governance rather than changed management. I'm wondering who's responsible for the

changed management?

A. Well, I would suggest the changed management is in terms of the timely delivery of the service programme framework, the framework programme, because that would include, if you're putting specific targets against different elements within that framework which require change and change in management, part of the programme board's remit would be to oversee that. Now, I can come back to the Inquiry with specifics on that if that's helpful. 12:04

186 Q. MR. DORAN: I was wondering would a document such as the service framework be publicised to the families of patients at a facility like Muckamore?

A. Again, I'm not sure whether it was published. I would assume it was a publicly available document. Again, I can check that for you, Mr. Doran. I'm not sure whether it was publicly available and, if it was, if it was specifically given to families at Muckamore. 12:04

187 Q. Are you aware whether there is a complaint mechanism that could be used if a patient or a family member was not satisfied that the relevant standards in the document had been met? 12:05

A. I'm not sure whether it's a specific complaint mechanism within the framework or whether it's just the normal complaint mechanisms for any Trust-delivered service. But again, we can come back with specifics on whether it's -- sorry, I have not gone through that in enough detail to say whether there's a complaint mechanism in there, Mr. Doran. 12:05

188 Q. Well, it's something we can pick up on perhaps at a later stage. You'll forgive me if I just jump ahead a little bit in your statement. We're now in that territory that lies between modules 2 and 3. I wonder if paragraph 5.17 could be brought up on screen, please. That's at page 23. You say at paragraph 5.17: 12:05

"The Service Framework Programme Board decided in 2018 not to renew the Learning Disability Framework. I attach a copy of a letter advising of this decision at Exhibit 45." 12:06

Exhibit 45 then is at page 2523. Let's just have a look at this correspondence. It's from the Chief Medical Officer, Dr. Michael McBride, and it's dated 22nd March 2019, and it's sent to Mrs. Valerie Watts, Chief Executive, at HSCB, PHA. If you could just scroll down, please. The letter reads: 12:06

"Dear Valerie, Service Framework Programme. 12:07

The Service Framework Programme Board met in December and discussed the current position of the programme and what should be done next. I have been briefed on the conversation at SFPB and the decisions taken and felt it was best to formally communicate the Department's position to you and the wider HSC. 12:07

"RQIA was asked to carry out a review of the service

framework programme, but due to competing priorities this work has been paused. It is not clear at this time when the review will recommence. In the meantime, a number of service frameworks (respiratory, learning disability and cardiovascular) have come to the end of their life cycle, with another (older people) due to end this year?

"The SFPB is content that under the circumstances these service frameworks will conclude and I am not examining to commission the HSCB/PHA to develop new service frame works in these areas. In addition I am not proposing RQIA conduct a formal review of each framework as has been the case up to now.

"I would ask that any KPIs rated as either amber or red will continue to be worked on by the Trusts in collaboration with the service framework lead to address the deficiencies identified."

KPI stands for "key performance indicators" presumably?

A. It does, yes.

189 Q.

"With regard to the three service frameworks in development, the SFPB is content that the children and young people and mental health frameworks are processed to the point of being ready for launch but that any further work will be paused until the SFPB will make a decision on the future of the programme."

I needn't read the remainder of the letter. The basic point is that the Service Framework Programme Board was contend that the framework would conclude, and they were not going to commission the board and the Public Health Agency to commission new service frameworks in certain areas, including learning disability.

Can you give any insight, further insight, into how that decision was taken and the rationale for it? 12:09

A. I'm sorry. Other than what Professor McBride has said there in the letter, Mr. Doran, I can't. Not being there at the time, I don't have that information available.

190 Q. But that's a matter that could presumably be explored for the Inquiry? 12:09

A. Absolutely.

191 Q. I assume then that you can't tell us today how the Department actually satisfied that it was, in fact, appropriate for the Learning Disability Service Framework not to be renewed at that point in time? 12:09

A. I can give some information on where it has gone since then which might give a bit of context. I can't give the specifics of where it had got to at that stage.

192 Q. Well, that would be helpful. I was going to ask whether it had been replaced by a new document, obviously of another nature? 12:10

A. A piece of work was subsequently undertaken by the Health and Social Care Board in terms after Learning

Disability Framework. That piece of work was taken forward as part of the work -- it was funded by the confidence and supply arrangements with Her Majesty's government, as it was at that stage, and specific money was allocated to take forward a learning disability, work on a learning disability service model.

193 Q. Just slow down a little bit, please.

A. Sorry. Apologies, Mr. Doran.

194 Q. No, no, that's absolutely fine. I was just going to ask is that the initiative you refer to at paragraphs 5.22 and 5.23 of your statement? 12:10

A. That's the exact one, yes. That work was taken forward by the board, as it was at that time. As you said, the draft service delivery model was provided to the Department in October 2021. 12:10 12:11

Now, since then, we have looked at the model which was provided by the board, we have been backwards and forwards with the board on a number of occasions and that work has now been subsumed into a learning disability strategic plan, which is ongoing at present to work out how the Learning Disability Service model and the Children With Disabilities Framework can both be implemented and driven forward as one model. We are currently looking at a learning disability service model -- or learning disability strategic plan, which looks at an individual with learning disabilities and how their needs are met from cradle to grave. 12:11 12:11

Now, at this stage that is ongoing work but I'm happy to provide the Inquiry with the terms of reference, et cetera for the work that is ongoing at present.

That work stalled slightly because the Department, when we got it in October 2021, we were in the middle of Covid at that stage as well, Mr. Doran, so some elements of that work had to be stalled. It didn't have a fully costed plan attached, or delivery model attached to the plan. We were backwards and forwards with the board on a number of occasions on relation to that. The board are now -- or SPPG are now heavily involved in the current work, looking at a wider learning disability service plan or strategic plan. That is now part of that work which is now being driven forward. 12:12

195 Q. Will the plan be a similar type of document then to the service framework?

A. I don't think it will be as detailed, if I'm honest with you. We're working with Trusts. Trust directors are part of that working group as well looking at it so we will need to see how best it will delivered when we come to the end it. But I don't think it will be as detailed as the Framework document that we have exhibited today. 12:12 12:13

196 Q. And is there a draft document in place?

A. We have a terms of reference -- there is a draft learning disability service model, which is the document produced by the board. I'm not sure whether

we have exhibited it at this stage or as part of my statement, but I would be content that that could be exhibited to the Inquiry. It may be beneficial in terms of looking at where we'd got to. As I say, I am more than happy to provide the terms of reference for the learning disability strategic plan work we are currently doing.

197 Q. But at the moment, the position as regards the Learning Disability Strategic Framework is that that's in abeyance? 12:13

A. It would be in abeyance, yeah.

DR. MAXWELL: Does that mean there's no framework, there has been no framework from 2018 to this point in time that's current; that's currently in use?

A. Could I come back to the Inquiry with a specific answer on that? I don't know the exact detail and I wouldn't like to speculate. But I will come back with a specific answer. 12:14

DR. MAXWELL: Please. Also if there isn't, how is the service held to account if there are no standards to hold it to account to? 12:14

A. Yes. I'll come back with specifics on that too.

CHAIRPERSON: I think the Inquiry is interested in this.

A. Yes, Chair. 12:14

CHAIRPERSON: Because this letter, if you look at it at the sort of moment in time, is slightly odd in the sense that it seems to indicate the RQIA are asked to carry out a review, but they don't; there's a

recognition that there are KPIs that are still either - what is it - yellow or red, and then they seem to abandon the framework.

A. Chair, I will come back with the detail. I'm not as over the detail on this module. 12:14

CHAIRPERSON: No. This is no criticism of you at all but it's just to give a signal that I think we are interested.

A. That's fine, Chair.

CHAIRPERSON: Thank you. 12:15

A. Thank you, yes.

198 Q. MR. DORAN: That's the third of the oversight arrangements that we've looked at. I want to go on now and look at the fourth and final one, which we've touched on already, and that's the Muckamore 12:15 Departmental Assurance Group. You refer to the group at paragraph 4.12. If we can go back then to page 19, please?

At paragraph 4.12, you say: 12:15

"Following the publication of the independent report into allegations of abuse into Muckamore Abbey Hospital in December 2018, A Way to Go, the Department established the Muckamore Departmental Assurance Group 12:15 (MDAG) in 2019."

Just following on from our earlier exchange at the beginning of your evidence this morning, it seems that

MDAG resulted from the Way to Go report; is that correct?

A. Partly from that and partly from the RQIA inspection in March/April 2019, and some of the findings from that RQIA inspection. 12:16

199 Q. This was following on from the revelations of 2017?

A. It would have been following that, yeah.

200 Q. You say then:

"The group has a remit to oversee delivery of the actions in the MAH HSC action plan (Exhibit 35) which the Department developed to address the recommendations within the A Way to Go report and improve learning disability services as well as providing assurances about the safety of services at Muckamore Abbey Hospital. Until recently, the group was jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer. While outside the Inquiry's terms of reference, it should be noted that, following reorganisation of responsibilities within the Department, the chair of MDAG has now moved to the Deputy Secretary's Social Services Policy Group and the Chief Nursing Officer." 12:16 12:16 12:17

Now, when you say outside the Inquiry's terms of reference, I take it you're referring simply to the date of that change? 12:17

A. Absolutely, Mr. Doran, yeah.

201 Q. But obviously the subject matter with which this group

deals is very much within the Inquiry's terms of reference?

A. If I could maybe just explain that slightly, if that would be helpful?

202 Q. Yes, please do. 12:17

A. In terms of the reorganisation, the previous post holder, who was Deputy Secretary for the Social Services Policy Group, was also the Chief Social Work Officer for Northern Ireland. That was Mr. Sean Holland. Sean has now moved on to another department 12:17 and his replacement then took over the responsibility of purely the policy end of the Social Services Policy Group, and the Chief Social Work Officer then transferred to Áine Morrison within the Department. I know Áine is giving evidence to the Inquiry at a later 12:18 stage. It's just to reflect it was purely internal rather than sort of any suggestion of the role that the Chief Social Work Officer took previously. I think it was a reflection of the breadth and the pressure on that role for one post holder that the duties were 12:18 split.

203 Q. I think Ms. Morrison is giving evidence specifically in relation to an earlier report --

A. Yes.

204 Q. -- during these evidence modules. 12:18

A. Yes.

205 Q. But we can certainly follow through on the various matters that you have raised.

Now, in your exhibits there are two copies of this document which is called the MAH HSC Action Plan. I'll not bring you to the first one, it's at Exhibit 49.

A. Yes.

206 Q. For the record, page 2546. You explain, I think, later in your statement at paragraph 5.26 that that document was updated to reflect the recommendations of the governance review, which we'll be looking at in due course. Isn't that correct? 12:18

A. Yes. The exhibit at number 49 is the original HSC action plan. Exhibit 35 includes the leadership and governance review obligations. 12:19

207 Q. That is at page 1365, if that could be brought up on screen, please. If you could scroll down, please. This is the introductory section of the action plan. I'm not going to drill into all of the detail but it's described in the introduction as a live document. Could you just scroll down, please, to the next page. At the final paragraph: 12:19

"In this context, this plan should be considered a live document which will be subject to ongoing review and development to drive further and emerging improvements to current practice." 12:19

So, does it remain a live document? 12:20

A. It does, Mr. Doran. We would look at a version of this at every MDAG, and supported that at every MDAG. Now, I would say since this document has been submitted to

the Inquiry, we have refreshed it slightly as well. We found that where there are so many recommendations, it really was losing some of its value in going through every single recommendation at every MDAG. So, we have now put those into the four thematic areas and we are reporting against the thematic areas in the report. Those areas would be around resettlement, workforce, safeguarding and then the leadership and governance recommendation. So that's what I mean by a live document, you know. We continually review this to see if it's serving the purpose, both in terms of us delivering against the recommendations and sort of the value it brings to MDAG and the membership of MDAG. 12:20 12:20

Again, the next version of it is still under discussion with MDAG around how that will be reported on at each MDAG meeting, but we can provide an updated version to the Inquiry, if that's helpful. 12:20

208 Q. Yes, the understanding being that it's a draft --

A. Yes. 12:21

209 Q. -- and not yet completed.

A. Yeah.

210 Q. That's very helpful. Is MDAG the sole mechanism for monitoring how the action plan is progressing?

A. It's the most formal mechanism. As a department, we would hold regular meetings with Belfast Trust colleagues as well. Obviously the resettlement element of this is now being delivered by the Resettlement Oversight Board, chaired, as I said earlier, by 12:21

Patricia Donnelly. So, there are a number of mechanisms. It's not that we simply look at this every two months; myself and my team would have regular discussions with Belfast Trust around the issues within the document. We also have responsibility in terms of a number of judicial cases where we have to engage directly with some of the patients -- some of the families of patients still within the hospital. Again, we would talk to the Trust and provide minutes of meetings with the Trust to that individual family where we have a responsibility to do that as well. 12:21 12:22

211 Q. Would those discussions then feed back into the MDAG meetings?

A. The family members who we would deal with, particularly in terms of that judicial direction, are one of the family members who represent the families on MDAG as well, so those discussions do fold back in. We try to ensure that MDAG looks at the totality of issues as opposed to getting into specifics of individual cases, because we do deal with those outside. Largely, that is the responsibility of the Trust to engage with the families, but where we have a direction from the court in one particular case, we do deal directly with that family on a regular basis. 12:22 12:22

212 Q. I think you have indicated that the MDAG minutes are all available on Departmental websites? 12:22

A. On the Department's website, they are available, yeah. But if it's helpful, Mr. Doran, we will supply them to the Inquiry as well, if that is helpful.

213 Q. Yes, thank you, that would be of assistance.

Now, just looking at how the monitoring process works, let's just take an example from the document. It's not an entirely random example, it's a topic in which I think the Panel will be interested. If one goes to page 1390, please. You see, just beneath the blue box: 12:23

"SAI hospital staff recommendations". Recommendation 13 says: "An enhanced role for specialist nursing staff is set out." 12:23

The next column is Belfast Trust. The next column, A29. Then the text in the next column says:

"By 30th June 2020, develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work. 12:24

"October 2020, update. The divisional nurse is currently working with the Departmental Lead Group, and benchmarking of staffing is occurring across various LD hospital sites in the UK." 12:24

If you could scroll down, please. 12:24

"December 2020. No further update available at the moment. Query extended target date."

Now, I wonder how exactly would that kind of recommendation be monitored?

A. My team in the Muckamore Abbey assurance team, who work as part of my directorate, would monitor that with Trusts. We go out to Trusts on a regular basis to seek updates against each of the actions in the action plan. They would challenge the Trust around the deliverability of those actions, and then they report back. At the time this was the model of reporting back to MDAG. So, there is a continual function within my branch in my directorate who are looking at Muckamore issues, and they would challenge the Trusts against each -- the Trusts or whoever is responsible against each action. Some of the actions fall within my remit in the Department as well. So it is around that, whoever is responsible for it, we would seek updates. Those updates are then provided to MDAG and family members, RQIA, PCC. The other members could then seek updates and challenge -- not necessarily challenge the Trusts is maybe an incorrect term, but they could seek additional information from the Trust based on the information provided on the updates against the action plan. 12:25 12:25 12:25

214 Q. How would one find out exactly the up-to-date position? I mean, for example, if one were to ask, well, what's happening now with recommendation 13, would it be possible to obtain that kind of information? 12:26

A. As I say, we've gone away from reporting against each individual recommendation. You can see yourself that

is quite a weighty document to try and go through in a couple of hours' meeting, you know. So we have gone away from that. For example, that recommendation there is probably around the workforce issue, so that would now be folded into a thematic theme of workforce issues and they would be reported on against that at current MDAG meetings.

The MDAG meetings, we do tend to try and, as I say, keep it on a more high level basis, although we do allow all members to drill down into the detail if that's what is required. The meetings normally last around two hours. It is difficult at times to get into all of the detail contained in an action plan of that size, which is why we took the decision and took that recommendation to MDAG a number of months ago to change it to a more thematic-based reporting structure. 12:26 12:26

215 Q. In the new version, the draft document to which you've referred, there may, for example, be some updated information in relation to recommendation 13? 12:27

A. It probably wouldn't go down as detailed as recommendation 13, but it would probably be around workforce issues in totality rather than drilling down to an individual recommendation.

216 Q. Just as a very practical matter, will there be a way of reading across from the earlier drafts to the new drafts? 12:27

A. There will not be something which says "this is in relation to recommendation 13". The thematic group,

the thematic reporting will now say these are workforce issues. We can always refer them back to where they sat within these original documentations. It's not that we have lost sight of any of the recommendations which need to be delivered, it's really around how we report against those to make it more manageable, and sort of a better meeting for MDAG to ensure that we do get the business done in the MDAG meeting as well. But we have not lost SIGHT of the recommendations. 12:27

Indeed, I mentioned earlier on about the review carried out by Bria Mongan and Ian Sutherland in terms of the resettlement review. Those actions again have been subsumed within the MDAG or around the resettlement. So, rather than having different structures to report against different reports, they're all delivered through this MDAG structure. 12:28

DR. MAXWELL: Can I just ask about that? There are very specific targets that are rated red?

A. Yeah. 12:28

DR. MAXWELL: And you are saying that rather than have everything reported on a very big document, there are now subthemes?

A. Yes.

DR. MAXWELL: In the subgroup that's looking at workforce, for example, are they keeping an eye on the red rated recommendations? I understand that at the full group, you can't go through everything, but are the subgroups still looking at the individual 12:28

recommendations?

A. Well, the subgroup reference there -- let me just go back to 1391.

DR. MAXWELL: The new workforce them subgroup.

A. There's not a workforce subgroup, themed subgroup as such. All of these issues would be taken forward. For example, that specific recommendation there is against Belfast Trust, so that would be a responsibility for Belfast Trust to take forward. So, MDAG will continue to monitor Belfast Trust's deliverability against each individual target but the reporting coming back will be on more a thematic basis. So, as I say, we have not lost sight, we have not lost sight of the individual targets and the individual actions that need to be delivered against. 12:29

Quite a number of those targets, you know, in that one for example, by March 2021 we suggest that we update to amber as opposed to red; it was sitting at red because we had not hit the original target date but we felt it was better to reflect that there was work ongoing, which is why it was changed to amber. A lot of the reds were because there was a specific date. We didn't hit that target date, so therefore the assurance rating was sitting at red because we had not hit that date. Whereas if there was work ongoing, we believed it was better to reflect that as a work in progress. 12:30

DR. MAXWELL: So this is not the risk rating, it's not the five by five risk rating?

A. No, it's basically -- it gives a red/amber, a risk rating; a red, amber or green rating against how well we have delivered against each of the individual targets within that.

DR. MAXWELL: Which does beg another question: Do you risk rate each of the recommendations using the five by five matrix? 12:30

A. Not for this specific.

DR. MAXWELL: So we don't know which of these recommendations are the highest priority because they have not been risk rated? 12:30

A. Not for the specific -- the delivery of the MDAG reaction plan.

DR. MAXWELL: So MDAG doesn't do risk rating?

A. I would want to come back to the Inquiry on that, if I can, because I don't want to mislead the Inquiry. If it's possible, I can come back. 12:31

DR. MAXWELL: It would be interesting to know how the different recommendation list is created, or if that is done. 12:31

MR. DORAN: It occurs to me, Chair, members of the Panel, that if the Department provides the updated information to which reference has been made, we can then pick up on some of these matters at the beginning of the next evidence session in a few weeks' time. 12:31

A. That's okay.

217 Q. Indeed, as we've agreed, these issues straddle topics 2 and 3. I think this is probably the natural place to start next time, next time round.

Can I just ask, is it the intention that MDAG will remain in place then until the hospital is closed?

A. That would be our intention. Yeah, that would be.

218 Q. Before I finish, I have a specific query arising from one of the reports that you mention in the next section of your statement at paragraph 5.11. You may not be able to give an answer to this specific question. If you can, well and good. If not, perhaps it's a matter that could be explored for next time. 12:32

You refer in paragraph 5.11 to the Transforming Your Care report. I wonder if specifically page 2259 could be brought up on screen, please. This is a passage within the Transforming Your Care document from 2011, and it's made in the context of resettlement. I wonder could you just scroll down a little bit, please. What is said in this report is: 12:32

"There are currently around 200 long-stay inpatients in learning disability hospitals who should be resettled into the community." 12:33

Now, that was the figure in 2011. Do you know what the equivalent figure is today? 12:33

A. There are currently 29 patients to be resettled within Muckamore. There are some delayed discharge patients in other learning disability hospitals, for example, Lakeview. I think there are two in Lakeview who we

would class at delayed discharge patients. But there are 29 -- when the Learning Disability Oversight Group, or the Resettlement Oversight Group starred its work, there was 36 within Muckamore. That's now down to 29. We discuss each of those patients individually every fortnight at that resettlement board.

PROF. MURPHY: Sorry, could I ask you, those are the resettlement patients in Muckamore but what are the number of assessment and treatment beds in Muckamore, because that's a much bigger number, isn't it? 12:34

A. My understanding would be there are currently no patients within Muckamore under assessment and treatment. It's pure there are 29 patients within Muckamore and they are all to be resettled.

CHAIRPERSON: So that's the total number? 12:34

A. The total number within Muckamore is 29.

PROF. MURPHY: And there's no assessment and treatment beds?

A. That's my understanding, yes.

PROF. MURPHY: Thank you. 12:34

A. Sorry, there's no patients under assessment and treatment rather than no assessment and treatment beds, which is quite a nuance in terms of commissioning. But there are no patients under assessment and treatment within Muckamore at this stage. 12:35

PROF. MURPHY: Thank you.

MR. DORAN: Now, Mr. McGuicken, my prediction that my questions would run into the afternoon has been proved wrong. Those are all the questions that I have for you

today in this first period of evidence. You will, of course, be returning on two subsequent occasions to give evidence before the Panel. It may be that the Panel will have some questions to put to you before we finish this morning's session? 12:35

CHAIRPERSON: No, I think we've covered things as we've gone along, probably to your frustration, Mr. Doran, as we've interrupted.

MR. DORAN: To my benefit, Chair.

CHAIRPERSON: So, I think that's all from us. 12:35

Can I just thank you very much, Mr. McGuicken, because not only did you produce a very full statement, but I know how much preparation this sort of day takes and to be able to answer as fully as you have. There are 12:36 obviously a number of outstanding issues that we will come back to, but I am grateful for the time you've obviously taken to prepare your evidence today.

THE WITNESS: Thank you very much, Chair.

CHAIRPERSON: Thank you very much and we will see you 12:36 again. Although you are a current witness to the Inquiry, this isn't, as you know, court. Normally, you'd be in purdah, as it were, and not allowed to talk to anybody at all until you came back the next time. That doesn't apply to the Inquiry. But if you do 12:36 receive further information, we would like to know what it is on the next occasion.

THE WITNESS: Thank you.

CHAIRPERSON: So thank you very much.

THE WITNESS: Thank you, Chair.
CHAIRPERSON: Okay. So two o'clock?
MR. DORAN: Yes, Chair, two o'clock. Mr. Dawson is giving evidence on behalf of the Public Health Agency in relation to module 2, topic C, the agency's role in organisation and commissioning of services at the hospital and quality recruitment. 12:36
CHAIRPERSON: Thank you very much. We'll see you at 2:00. Thank you.
12:37

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you. Yes, Mr. McEvoy?
MR. McEVOY: Thank you, Chair. Thank you, Panel. This afternoon the Inquiry will hear evidence from Aidan Dawson on behalf of the Public Health Agency. It's a brief statement, Chair, and there aren't any exhibits. 13:57
CHAIRPERSON: Yes.
MR. McEVOY: If Mr. Dawson could be called, please.
13:58

MR. AIDAN DAWSON, HAVING BEEN SWORN, GAVE EVIDENCE TO THE INQUIRY AS FOLLOWS:

CHAIRPERSON: Thank you, Mr. Dawson. Welcome to the Inquiry and thank you for your statement. As you know, Mr. McEvoy is going to be asking you questions. 13:58

THE WITNESS WAS EXAMINED BY MR. McEVOY AS FOLLOWS:

MR. McEVOY: So, Mr. Dawson, we met briefly earlier this afternoon. As you know, my name is Mark McEvoy, I'm one of the Inquiry counsel. 13:59

You have provided to the Inquiry a statement of nine pages in total dated the 16th March. Do you have that statement in front of you?

A. Yes. 13:59

219 Q. Do you wish to adopt that statement as your evidence to the Inquiry?

A. Yes.

220 Q. There are no other exhibits or documents attached to that statement; is that right? 13:59

A. That's correct.

221 Q. At the outset of your statement, which begins at 094 -- maybe we'll bring it up on screen so everyone can follow along - you tell us your qualifications and then you set out your current position as Chief Executive of 13:59 the PHA. Can you tell us when you took that post up, please?

A. 1st July last year. So, on 1st July this year I'll be two years in post.

222 Q. Can you tell us something of your career before taking 13:59 up that post?

A. So I have worked over 30 years between the community and voluntary sector and the Health Service. Most of the last 20 years in Trust, Greenpark Health Care Trust

initially in RQIA until around 2006/2007. Then, when it was incorporated in the wider Belfast Trust as part of RPA, I took a post as a co-director for trauma and orthopaedics and rehab medicine in the Belfast Trust.

223 Q. Overleaf at page 2, at the very top of page 2 of your statement, you tell us that your role is to be accountable to the board of the PHA for the efficient and effective management of the organisation and ensuring it meets objectives set by the Minister and Department of Health. 14:00

Are specific objectives set for you on learning disability and mental health --

A. No.

224 Q. -- by the Department of Health? 14:01

A. No. They are more broader objectives about the running of the organisation and how it performs. I am the accountable officer, so obviously keeping within budget is a statutory responsibility. But there was nothing. My objectives on a yearly basis would generally be set by the Chair of the Public Health Agency. There's nothing in that in the previous year regarding mental health and learning disability, nor any other service specific issue. 14:01

225 Q. You've described your role - when I say your, I mean the agency's role - as: 14:01

"... including a commitment to addressing the causes and associated inequalities of preventable ill-health

and lack of well-being. It's a multidisciplinary, multiprofessional body with a strong regional and local presence."

That's just the next paragraph down. 14:02

Where does mental health and learning disability fall within that rubric, broadly?

A. I suppose in recent times we have been focused more on the sort of policy and early intervention, so ensuring 14:02 people maintain good mental health and building the resilience of local communities to be better prepared for their mental health and wellbeing as with their physical health as well.

14:02

We would also be involved with the SPPG, which was formerly the Health and Social Care Board, with regard to commissioning of services in sort of the wider Trusts. We would also commission services from the community and voluntary sector, such as talking 14:02 counselling services as well around mental health.

226 Q. So, that's all about mental health. What about learning disability?

A. Learning disability? I could look into -- there's nothing which immediately comes to mind regarding 14:03 learning disability. Much of it's mental health with the community and voluntary sector. The commissioning of learning disability is traditionally led by social care. Whilst we provide professional input into

commissioning social, social care advice is not part of PHA's remit, and that comes from SPPG itself.

227 Q. So, given that one of the principal things, one of the principal tasks or commitments that the PHA has to have is to address the causes and associated inequalities of preventable ill-health and lack of wellbeing, what has been the focus, if at all, on learning disability since you took over? 14:03

A. I'd say mainly since I would have come into post, my focus has been on addressing the pandemic, which is Covid, and really only within the last sort of six months, when we have sort of returned to rebuild and come back to normal, as it were, as a healthcare system and a public health agency. Because a lot of our resource in my first 18 months in charge would have been focused primarily in addressing pandemic issues. 14:04 14:04

228 Q. So?

A. So very little, I would say.

229 Q. Very little examination or a scrutiny of public health -- 14:04

A. Yes.

230 Q. -- of learning disability?

A. Very little since I came into post. Now, there may have been more before that, perhaps when we were in normal time, but quite a few of the senior officers of the agency have perhaps left in the last number of years due to retirement, et cetera. Therefore, our organisational memory is quite poor around some of that. 14:04

231 Q. Have you taken any soundings from your predecessors about attention on learning disability?

A. Yes. I've met with Briege Quinn, who would have inputted into commissioning arrangements. She's a retired Assistant Director of Nursing. So whilst none of our medics would have inputted, some of our nursing colleagues would have inputted into commissioning decisions around mental health and learning disability in the past. 14:05

232 Q. Did you speak to her for the purposes of preparing this statement? 14:05

A. Yes.

233 Q. You go on in the next paragraph of your statement to tell us that in:

14:05

"... fulfilling your mandate to protect public health, improve public health and social wellbeing and reduce in qualities in health and social wellbeing, the PHA works within an operational framework of three areas: Public health, nursing and allied health professionals and operations." 14:05

There's expertise on the Inquiry panel, but this is a public Inquiry so it would be very helpful if you could explain in terms readily understandable to the lay person what that means. 14:06

A. Okay. So we have a group of, I suppose -- under public health we would have our public health consultants, the majority of which would be medically qualified,

although you don't have to be qualified as a doctor to be to become a public health medic. They would input professional advice on a broad range of issues, working in tandem with colleagues from SPPG or formerly the Health and Social Care Board. They may address such issues as to workforce or pathways or other areas perhaps of professional advice, so mainly focused on public health.

Then on the nursing side of things, we would have a range of professionals and allied health professionals as well, which would be speech and language therapy, occupational therapy et cetera. Again, they would input professional advice to SPPG with regard to commissioning. Does that help? 14:06 14:06 14:07

234 Q. Well, as you know, the Inquiry's focus is on issue of mental health and learning disability at Muckamore Abbey.

A. (Witness nods).

235 Q. And you're here today giving evidence to the Inquiry because the Public Health Agency has been specifically identified as an agency within the terms of reference. 14:07

A. Yes.

236 Q. It would be very useful for the Inquiry to understand within each of those three areas the percentage or proportion, whichever you prefer, of your resources that you use or devote to learning disability and mental health. Take them in turn, please. 14:07

A. Okay. So within public health, which is the doctors'

side of the house, we would have a specific doctor who would be focused on mental health and learning disability. Now, they have advised that with regard to Muckamore Abbey, they have not inputted because most of the care was social care, and had not inputted previously in the past to that.

On the nursing side of things, again we would have an Assistant Director in Nursing For Mental Health and Learning Disability. They would have worked with colleagues in SPPG to input advice into commissioning regarding learning disability and mental health.

But proportional time, I wouldn't be aware of because they would obviously cover the whole gambit. 14:08

237 Q. Proportion of resources; budget?

A. Oh, I wouldn't know the answer to that, I have to say. It's one assistant director, and I think we have eight. But I'm quite happy to find the answer to that and come back to the Inquiry. 14:09

CHAIRPERSON: Can I just get an idea of numbers because I don't have any understanding at the moment from your statement about how big the PHA is. How many people do you employ?

A. Approximately 350. It sorts of rises and falls. It was up over 400 during Covid but has fallen back somewhat as well. 14:09

CHAIRPERSON: Right. Are you based within the Department of Health or elsewhere?

A. No, we are an agency. We're what's referred to as --

CHAIRPERSON: And arm's length body?

A. An arm's length body.

CHAIRPERSON: Where are you based?

A. We are based in Linenhall Street in the centre of Belfast, and we would share a building with the SPPG. 14:09

CHAIRPERSON: Right. Just to give us some sort of understanding, you've mentioned you would have one doctor who gives advice on mental health and one nurse who is a learning disability trained nurse? 14:09

A. Yes. Well, they are an assistant director covering mental health and learning disability. I wouldn't know exactly their professional background but that is what they are employed to give advice on.

CHAIRPERSON: Apart from those two, who else in your agency would be focusing on mental health and learning disability? 14:10

A. We have a range of professionals and depending on what area they were covering, they are not specifically focused on mental health and learning disability. So, if there was an issue came up regarding occupational therapy, it would go to the occupational therapy lead, but they wouldn't necessarily be focused the whole time on occupational therapy with regard to the mental health and learning disability. 14:10 14:10

But any of those professionals which we employ in speech and language therapy, occupational therapy, podiatry, could be asked to give advice on any aspect

of service because of the way that we work.

CHAIRPERSON: Okay. Sorry to interrupt, Mr. McEvoy.

238 Q. MR. McEVOY: Okay. So picking up on that then, to use your last example, could a podiatrist be asked to input in relation to the needs of persons with learning disabilities in a hospital setting such as Muckamore? 14:11

A. They could.

239 Q. Do you know has that type of thing happened before?

A. I wouldn't be aware, but it could happen. It wouldn't be unusual or unrealistic. Any issue that came up regarding the podiatry across all the services in Northern Ireland, if there is a podiatry issue and it needed input, our podiatrists would provide that, regardless of if it was mental health or acute services for children et cetera. 14:11

240 Q. All right. Would a podiatrist - just to use that example - liaise with the lead on - I mean, I'm assuming there is a lead on learning disability?

A. The Assistant Director For Mental Health and Learning Disability. 14:12

241 Q. That person is the lead?

A. Yes.

242 Q. So would a person such as a podiatrist or speech and language therapist --

A. Yes. 14:12

243 Q. -- they would liaise?

A. They would work in multidisciplinary groups, yes.

244 Q. You mentioned the Safeguarding Board for Northern Ireland.

A. Yes.

245 Q. That organisation, if I understand it correctly, or the board and the enabling legislation relates to the welfare of children and persons under 18?

A. Vulnerable people, yes. 14:12

246 Q. Vulnerable people?

A. Yes. All people but yes, specifically focused on vulnerable people.

247 Q. Can you explain how the agency's role as a member, as a corporate host, for that board works? What does that 14:12 mean in practice?

A. In practice it means that we provide a base for it to operate out of and we provide, basically, payroll function for it. We do not have any governance or accountability for its operations, as it were. But we 14:13 do -- our Director of Public Health and our Nursing Director do sit on their board as well.

Trying to explain it, it's a body which, because it's not big enough to be its own organisation, it has to be 14:13 hosted somewhere, but we have no influence over its operations or the services.

248 Q. But you're members of it?

A. We are members of it, as are the -- and we are bound to uphold any duties that we have to it in keeping with 14:13 all the other Trusts et cetera as well. But we are not -- it is not something which we have -- we don't have influence over its actions.

249 Q. But you're members of it?

A. But we are members of it, yes.

250 Q. Presumably, therefore, if it takes a decision at a board level, as a member you are bound by that decision then?

A. We are bound by that, as are all the other bodies as well, yes. 14:14

251 Q. What knowledge do you have about decisions it might have taken with regard to Muckamore?

A. None.

252 Q. And why is that? 14:14

A. Because I do not sit on the board. It's quite an enclosed body. We are only a host to it and, therefore its decisions, when they come, I may not be aware -- well, I don't think anything has ever come across my desk to date regarding it. 14:14

253 Q. Okay. So, you're the chief executive of the agency?

A. Mm-hmm.

254 Q. You're not sighted, is that your evidence to the Inquiry, you're not sighted on decisions taken by the Safeguarding Board notwithstanding the fact that the agency is a member of the board? 14:14

A. Yes.

CHAIRPERSON: Are there minutes?

A. They aren't sent to me. They would go to our Director of Public Health and Director of Nursing. It is quite a separate body to the agency. We are a host to it but it is not part of the agency. 14:15

DR. MAXWELL: I understand that, but you had two of your executive directors, two of your directive

directors, sitting on there.

A. Yes.

DR. MAXWELL: Do they not report back to you?

A. No. They provide -- their role is to provide advice into the board, not to act on behalf of the agency. 14:15

DR. MAXWELL: Can you tell me a little bit more about the relationship between the executive directors and you as a chief exec? I'm just slightly surprised, having been an executive director in NHS organisations, that they don't feed back to you. 14:15

A. Not with regard to the SPNI, no, they don't feedback to me on that because they act sort of independently, feeding advice into SPNI. SPNI is not part of the agency and, therefore, it doesn't report back in through our corporate body or to our board. It is not 14:16 responsible to the board of the agency.

DR. MAXWELL: I understand.

A. It's responsible to its own board.

DR. MAXWELL: I understand that, but I suppose - and I'm sorry, you may be coming to this - is the agency 14:16 not responsible for the advice its officers give?

A. Yes, it is.

DR. MAXWELL: It is?

A. (Witness Nods).

DR. MAXWELL: So the agency is responsible for the 14:16 advice that the two executive officers give, but you don't know what advice is?

A. No, because they give that independently as professionals.

CHAIRPERSON: Right.
A. It is -- the SPNI is quite separate to the PHA as an organisation.
DR. MAXWELL: Can I ask you a slightly different question then? I understand the HSCB didn't have a director of nursing, so the PHA Director of Nursing sat on HSCB and gave the nursing advice. Would you know what advice he had given? 14:16
A. No. It wouldn't come back through us because it's advice that she gave to the -- 14:17
DR. MAXWELL: So you think they are giving advice in a personal capacity rather than on behalf of PHA?
A. Yes. No, they're giving their advice in their capacity as agents of the SPPG, or SPNI at that point, not on behalf of the agency would be the way I would look at it. 14:17
CHAIRPERSON: Right. Thank you.
MR. McEVOY: Turning then to the next paragraph, which is paragraph 4 - and now we turn to module 2, which is the business of today, Mr. Dawson - we're told at paragraph 4 that the Public Health Agency does not lead on commissioning models and therefore did not lead on the commissioning of services at Muckamore Abbey. 14:17

"Commissioning of services" is a term that the public hears often but understands perhaps only a little. As Chief Executive of the agency, can you give us your perspective or definition indeed of what you understand by the term "commissioning of services"? 14:18

A. Commissioning of services is the decision to expend public money in procuring services for health and social care services to deliver to the population of Northern Ireland. In the commissioning act, you would seek to ensure that you get value for money and that appropriate health and social care social care services are being delivered in keeping with best practice and high quality of service.

255 Q. And what is a commissioning model?

A. A commissioning model is a multidisciplinary team coming together to purchase services from Trusts or other bodies across Northern Ireland. 14:18

256 Q. We're told, as you have indicated in paragraph 4, that you don't lead the agency and it doesn't lead on commissioning, and didn't lead on commissioning at Muckamore in particular. But not leading is not the same as not having any decision-making role -- 14:19

A. Mm-hmm.

257 Q. -- would that be fair to say?

A. That's fair to say. 14:19

258 Q. You mention at the bottom of page 3 a document, the HSC Framework document of 2011.

A. Mm-hmm.

259 Q. The document, coincidentally, was discussed at the Inquiry this morning so hopefully it can be brought up on the screen. The reference is 089 and the particular page is 1161. It might take a moment for that to load up. 14:19

If I can just go down to 235, please. Do you see at 235 where it says:

"Under section 8 of the (Reform) Act HSCB is required to produce an annual commissioning plan in response to the commissioning direction in full consultation and agreement with the PHA." 14:20

A. Mm-hmm.

260 Q. Then on down in the same paragraph, the last sentence:

"In practice, the employees of the HSCB and PHA work in fully integrated teams to support the commissioning process at local and regional levels." 14:20

A. (Witness Nods). 14:21

261 Q. I'm going to bring you to a number of these references but that would tend to show, wouldn't it, that the PHA is -- well, if you want to describe it as taking the lead or not, it's integral to the commissioning process; you would accept that? 14:21

A. I would.

262 Q. If you just scroll down please to the next paragraph, 236. On the same score then, if you just look at the next sentence along, there is:

"The HSBC is, however, statutorily required to have regard to advice and information provided by the PHA and cannot publish the plan unless it has been approved by the PHA." 14:21

So again, regardless of whether or not you describe your organisation as leading or not leading, nothing can happen without your sign-off?

A. Yes, they are symbiotic -- ourselves and SPPG are perhaps two organisations of a symbiotic nature in that we operate very closely together and one wouldn't be able to function out the other. So, that is correct. 14:21

263 Q. So you would want to correct any impression when you say in in your principal statement, you say the PHA does not lead on commissioning or commissioning models? It's different; you're integral to the commissioning process and nothing can happen in terms of commissioning without PHA say so? 14:22

A. Yes, they lead, but SPPG and Health and Social Care Board before that would lead very much in the commissioning process because they are the -- sort of the sort of organisation which holds the SLAs et cetera. 14:22

264 Q. Just explain that. What is an SLA? 14:22

A. Service level agreement, which would be signed off by the Trust chief executives and other providers of service. However, those cannot be reached, and shouldn't be reached, without professional input from our officers, where appropriate. 14:23

265 Q. Could we move down to page 1168, please, and at 3.6, please:

"Every year the HSCB is responsible for producing a

commissioning plan in full consultation and with the approval of PHA. The plan must outline how they plan to deliver on a key priorities, standards or targets set in PFI."

14:23

I understand, is that Priorities For Action?

A. Yes.

266 Q. Within the text of this Framework document, is the "they" a reference both to yourselves and the HSCB?

A. (Witness Nods), although my understanding is that that has not happened since I have been in post due to the pandemic. So, it would have been prior to that. Many of those who have processes were stood down during the pandemic and are now subject to rebuild. So, we didn't have a commissioning plan for sign-off this year.

14:24

14:24

267 Q. Sorry, can you just explain that again and a bit more slowly? So, it's your understanding that since you've been in post, so in other words it hasn't happened since you've been in post?

A. It hasn't happened since I've been in post.

14:24

268 Q. Do you know from your predecessor - and presumably there was some form of hand-over - what the process would have been then before you took over?

A. The annual sort of commissioning document would have been produced and it would have been provided to ourselves for comment before going -- before being accepted, to see if the priorities in it were appropriate for the population of Northern Ireland.

14:24

269 Q. Does that mean that there has been no plan or there is

a plan but nothing has been done with it from a PHA perspective?

A. There hasn't been a plan because the commissioning arrangements for Northern Ireland, as I understand it -- well, the commissioning arrangements for Northern Ireland are changing with the introduction of integrated care partnerships and services. Therefore, with that change in the way that plans are commissioning, there hasn't been one this year or last year. 14:25

DR. MAXWELL: Just a quick comment. You said things sent for comment, but actually the legislation says for approval, and there is a difference between commenting and approving.

A. Okay. Sorry, my poor use of language. It would have been approval. 14:25

DR. MAXWELL: Going back to your point earlier about the people who are looking at these things, are they approving on behalf of the PHA or as personal individuals? 14:25

A. It would be approved on behalf of the PHA.

DR. MAXWELL: So the PHA --

A. In that instance they are giving advice as officers in the Public Health Agency.

DR. MAXWELL: But the approval is from the agency? 14:26

A. From the agency, yes.

CHAIRPERSON: Sorry, this is a much simpler question. Remind me when you took up post again?

A. Not July last year, but the year before. That would

have been --

DR. MAXWELL: 2021?

A. -- July 2021.

CHAIRPERSON: Covid has been blamed for a lot and I understand that, but there's 350 staff, presumably only a portion of those were dealing with Covid? 14:26

A. Actually, quite a lot of our staff were redeployed during Covid to be acting wholly on Covid. So, the majority of the organisation's resources would have been acting on Covid. 14:26

CHAIRPERSON: And all of this just stopped?

A. Much of it would have stopped, yes.

CHAIRPERSON: I see.

270 Q. MR. McEVOY: What's the accountability mechanism then when no plan has been finalised? Who comes to you or comes to colleagues in the HSCB and says, number one, where is the plan if it hasn't arrived, or, number two, says this plan isn't finished, where's the rest of it? Where's the accountability mechanism? 14:26

A. It would come through our Director of Nursing and Allied Professions and our Director of Public Health because their multidisciplinary teams would review it for its approval. 14:27

271 Q. Just so you understand me correctly, who would hold the agency to account for the absence of a plan, or for the absence of it fulfilling its role to complete the plan? 14:27

A. I'm not quite sure what you're asking me, sorry.

272 Q. So you've indicated that no plan has been completed because of Covid.

A. Mm-hmm.

273 Q. That's the explanation you've given today to the Inquiry. Presumably that explanation has had to have been transmitted somewhere else, to those in authority?

A. The Department. In that case, it would be the Department of Health. 14:27

274 Q. Right.

CHAIRPERSON: Who in the Department of Health do you report to?

A. We have the Chief Medical Officer as our accountable officer in the Department of Health. They are our sponsorship branch. 14:28

CHAIRPERSON: Right. Thank you.

275 Q. MR. McEVOY: Would it be possible then to look at 1181, please? If we just look down at paragraph 4.17 there. The third sentence in: 14:28

"PHA is the lead organisation for supporting providers in areas of health improvement, screening health protection with support by the performance commissioning, finance, primary and social care staff of the HSCB." 14:28

A little bit earlier in your evidence, if I understood you correctly, you sought to delineate the role played by social care and those working in social care from the role played by your agency. Have I understood that correctly or -- 14:29

A. Yes.

276 Q. -- is there some misunderstanding on my part?
A. No. We don't have social care incorporated into the Public Health Agency. Any professional advice on that area would not be provided by Public Health Agency.
277 Q. But that sentence would tend to suggest, then - and this is in the Framework document - that that's not the end of the matter; that there's nothing to preclude you from moving forward with work and you are entitled to have regard to those with expertise or experience in social care? 14:29 14:30
A. Social care professions have usually reported through health and social care boards. They would have a Director of Health and Social Care, which would be Brendan whittle at this point in time.
278 Q. Yes. 14:30
A. So...
279 Q. You can have recourse to him while still being the lead organisation on those identified areas, health improvement, screening health protection; you can still have regard, you can still go to those people? 14:30
A. We can still have access through to Brendan but it was mainly his team which would take forward actions on social care. So it's not particularly an area that we would get into very often.
280 Q. If it's not an area that you get into very often then, and I might be asking you to speculate a little bit here, but what do you think the implications of that might be then for those in our community with a learning disability or with mental health needs? 14:30

A. Well, we work very closely with SPPG. As I say, our two organisations are combined very much together in the way that we work. Just the majority of the pieces of work regarding social care would sit wholly mainly within SPPG.

281 Q. I'm not sure I understand that answer. What you're saying is that, if I understand you correctly, the social care resource is not something -- albeit that this document appears to suggest that you can have recourse to social care input and advice, it's not something that you've actually activated?

A. Not in my time within the agency. Brendan does sit as part of our AMD, would give advice and does come to our board. But most of the work surrounding social care would sit with his officers within the agency, although they would work with our team members as a multidisciplinary team when required.

282 Q. What I was asking you was if you haven't had recourse to the facility to seek input from those with experience and expertise in social care, what does that then mean for your agency's ability to deliver for persons with mental health or learning disability needs?

A. I think I'm probably not describing it very well but we would work -- I don't think it would diminish any service that would be provided to people with mental health and learning disability. We have experts in that area, but they would work closely with our nursing experts as well to input as and when required.

283 Q. Could we bring up 1192, please. It should be paragraph 6.14, if you can find that.

CHAIRPERSON: Is this from the same document?

MR. McEVOY: Yes. Paragraph 6.14 says:

14:33

"The PHA is responsible to for monitoring and reporting to the Department on:- (i) Trust compliance with accepted standards for medical, nursing and allied health professionals, for example professional regulation and training and development. And; 14:33
(ii). Compliance with statutory midwifery supervision requirements.
(Iii). The identification and effective promulgation of learning from investigation of adverse incidents through the regional adverse incident and learning with 14:33
a real system and support for the development of quality improvement plans."

Then there is a fourth Roman numeral:

14:33

"Safety and quality aspects of PHA contracts with independent sector providers."

At first blush, Mr. Dawson, that's a very hefty burden of responsibility on the agency. 14:34

A. Mm-hmm.

284 Q. Would you agree that there's no delineation within that paragraph of the need to have lesser or greater regard for those looking after people with a learning

disability or mental health needs?

A. No.

285 Q. How often does the agency report and monitor to the Department on Trust compliance with accepted standards for medical, nursing and allied health professionals? 14:34

A. I don't know the answer to that. I would have to get that information for you.

286 Q. What about compliance with statutory - it's not relevant to this Inquiry - but with statutory midwifery supervision requirements, just for the sake of completeness? 14:35

A. Again, as I said to you, I don't know the answer.

287 Q. Then what about the identification and effective promulgation of learning from an investigation of adverse incidents; in other words, the real system? 14:35

A. That is an ongoing process. We would send out as required sort of learning letters or learning newsletters or host workshops, et cetera, to disseminate learning from SAIs.

CHAIRPERSON: But just thinking about this Inquiry for a moment, since the revelations of allegations of abuse at Muckamore since 2017, which will have given rise to a number, presumably, of adverse incident reports, would the PHA not be interested in those? 14:35

A. We do get all of the SAI reports and we would have an interest in those, and we are responsible for ensuring -- our team works closely with SPPG to review those incident reports and our primary role is to ensure that any learning that come out of SAIs is disseminated 14:36

across the region.

CHAIRPERSON: Right. So you will have had a role - not you but your agency - will have had a role?

A. It will have, yeah.

CHAIRPERSON: And have you been able to -- knowing that you were coming to give evidence to this Inquiry, have you had a look at what role the PHA actually played? 14:36

A. Our specific role is to take the learning from the SAIs when it is there, and also to appoint, where appropriate, responsible officers to review the SAIs as they come in. And we have. 14:36

CHAIRPERSON: And did that happen in the PHA?

A. Yes. Yes. Now, the process changed because of Covid, because, prior to Covid, we would have had medical advisors. During Covid, a new multidisciplinary team approach was devised to respond to SAIs. 14:37

CHAIRPERSON: Right. No, I understand. When did Covid start, was it 2020?

DR. MAXWELL: March 2020.

CHAIRPERSON: My colleague remembers it rather better than I, although I do remember the experience personally very well. But 2019/2020 before Covid struck, when these revelations were coming out about Muckamore, the PHA must have had an involvement? 14:37

A. Yes. 14:37

CHAIRPERSON: Right. Can you tell us about it?

A. It would have went through our multidisciplinary team to review those SAIs and extract whatever learning they felt was in them for distribution as part of the

learning process.

CHAIRPERSON: Right. And are there records about that?

A. Yes, which I think would have been submitted as part of the evidence in to the Inquiry, if they were.

CHAIRPERSON: That may be right, it's certainly not reflected in your statement, though. 14:38

A. Right, okay.

CHAIRPERSON: No, okay.

DR. MAXWELL: So would there have been learning reports that were published by the PHA? 14:38

A. Yes.

DR. MAXWELL: Would you be able to come back to us with all the learning reports relating to MAH from --

A. If there are, yes, I will come back with any learning reports, yes. 14:38

DR. MAXWELL: I think that would be very helpful.

288 Q. MR. McEVOY: I just have one other query and then the Panel may have some questions, Mr. Dawson. Obviously one of the specific areas we talked about earlier in your brief is addressing the causes of associated 14:38 inequalities of preventable ill-health and lack of wellbeing. Would you say that your agency has done enough to address, or look at, the question of whether there may or may not be inequalities for persons with learning disabilities and mental health needs, 14:39 particularly in a hospital setting?

A. I'm not sure, as a whole, as an organisation. I suppose what I'm saying is we could probably, as all the systems, could do more. What I would point to is

the fact that the inequality gap across Northern Ireland has not closed, and our healthy living years has reduced, especially since Covid has come.

So, if you look at the evidence, you might suggest, no, we have not done enough. But that's for the whole population, including people with mental health and learning disability. 14:39

289 Q. Would you accept - and presumably you would - that those groups are people with particular vulnerabilities and needs? 14:40

A. They are.

290 Q. Has any thought been given to your agency prioritising those people, particularly in a hospital setting?

A. We are... at the minute we are focused on a ministerial priority of early intervention as opposed to hospital settings, at this point in time. 14:40

MR. McEVOY: Those are my questions, Mr. Dawson.

CHAIRPERSON: Well, what I'm going to suggest is that we take a short break, because you've been going for about 50 minutes now anyway. We're just going to take a ten minute break, if you don't mind, so we can just reflect upon whether there is anything else that we want to ask you. All right? We'll just take a ten minute break now. You'll be looked after by the secretary to the Inquiry. Thank you very much. 14:40 14:40

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you very much. Can I just say that we are aware that the PHA have provided material in relation to the document request, so some of the material that we've been talking about may be sitting there, as it were, in our files, although it might have been helpful if you'd produced some of it in your statement.

A. Sorry.

CHAIRPERSON: No, that's fine. I entirely accept that the PHA have assisted the Inquiry to that extent. I think you're coming back, in any event, on the 19th?

A. On the 19th, yes.

CHAIRPERSON: Okay. Well, it may be you'll want to look at some of this material.

A. I will. Okay.

CHAIRPERSON: In the meantime, Dr. Maxwell has a question for you.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

DR. MAXWELL: So the Public Health Agency has a role in quality improvement/service improvement. I was wondering if you could tell me a little about that historically and currently?

A. Okay. So currently we, again, host the HSCQI, which is The Health and Social Care Quality Improvement Group within the agency. They take their work as directed under the Alliance, which is basically a body, like a

board, which consists of the chief executives of the Trusts and the other arm's length bodies, plus representatives of the Department of Health, including ourselves, and they would set the work programme for that.

At this point in time, they are focused more on timely access to service. Their work programme this year is working across all of the Trusts with a central theme and focus on timely access to service.

They came, the HSCQI group, I think it was originally - now this predates me, so forgive me if I don't get it completely accurate - came out of the Donaldson report to the establishment of a quality and safety group within the service, and they were formerly known as the Safety Forum. They have grown out of that, I think came into the agency in 2019, but I could get you an exact date. Does that help?

DR. MAXWELL: Northern Ireland was well-known across the UK to be leading on quality improvements; some of the work I was doing was aware of these sort of things. Certainly we've seen in other evidence that PHA had a role in relation to the complaints forum. Are you aware of the agency being actively involved in any of the service improvement recommendations that were coming out of the complaints subgroup?

A. I'm not aware, no.

DR. MAXWELL: Okay. You go on to say -- you've said,

and you say in your statement as well, that the HSCQI, this successor to the Safety Forum, has not been engaged in any work relating to the oversight of services at Muckamore Abbey. As well as being a host, you've just told us that PHA is a member of that organisation? 14:57

A. (Witness Nods).

DR. MAXWELL: Do you know if they've considered the issues at Muckamore Abbey?

A. I'm not aware that they have, but I can check that. 14:57

DR. MAXWELL: And nobody from PHA has raised it with them that this might be an area for quality improvement?

A. No, they haven't.

DR. MAXWELL: Okay. In terms of quality improvement skills, I know there was a big push in Northern Ireland, and certainly lots of work from the Institute for Health Care Improvement from Boston, to improve staff skills. Does PHA have any people who are skilled in quality improvement methods and techniques? 14:58

A. Well, obviously we have a group of staff who work out of HSCQI who are all --

DR. MAXWELL: Who work, sorry?

A. Who work out of HSCQI who are all sort of quality improvement trained. Our core staff, it is one of the things we have discussed this year that we would like to see it more incorporated into our own staff as well, and that will incorporate into part of our business plan going forward as an agency. 14:58

DR. MAXWELL: Can you just clarify that point? There are staff associated with HSCQI who are employees of Public Health Agency?

A. Yeah.

DR. MAXWELL: And they have specialist quality improvement skills? 14:59

A. Yes.

DR. MAXWELL: So, they're your employees?

A. They are our employees.

DR. MAXWELL: And you're accountable for them. Can you direct their work? 14:59

A. Their work -- sorry, I didn't describe it very well. Their work is directed through the Alliance. We host them as an organisation. A bit like SPNI, they sit on part of the agency but their work is not directed by the agency, their work is directed by the Alliance, who are their oversight board. 14:59

DR. MAXWELL: So who is the employer accountable for them?

A. Pardon? 14:59

DR. MAXWELL: Who is the employer accountable for them?

A. We, as an employer, are accountable for them but their work is directed by the Alliance, which is chaired at this point in time by Dr. Cathy Jack, who is the Chief Executive of the Belfast Trust. But I am part of the Alliance as well, so the overall group directs them. 15:00

DR. MAXWELL: So you sit on the Alliance?

A. Yes.

DR. MAXWELL: So you are part of the group that's

directing the work?
A. Yeah, but the agency isn't solely responsible for the --
DR. MAXWELL: No, I understand that.
15:00
In terms of quality improvement skills and tools, does the agency have any role in promoting those, teaching the Trusts?
A. That's done from HSCQI. Only that we host the organisation that does that, yes.
15:00
DR. MAXWELL: So you employ the staff that do the equality improvement training for all the Trusts?
A. A lot of the training would have come in through the Scottish leadership over the last number of years.
DR. MAXWELL: And was that housed in PHA; was it commissioned through the PHA?
15:00
A. Parts of it were, yes.
DR. MAXWELL: Which parts?
A. I think the fellowships were commissioned through PHA, but I can check for you.
15:01
DR. MAXWELL: Okay.
A. But I think the Trusts also would have commissioned quite of their own piece of work through that as well.
DR. MAXWELL: If I could just ask you one more question, about the nursing team at PHA. As you mentioned, there is or there was a post, Assistant Director of Nursing For the Mental Health and Learning Disability and you mentioned you had spoken to you colleague who had retired. Does that post still exist?
15:01

A. Yes, that post does.

DR. MAXWELL: Is there somebody in post at the moment?

A. I think it's in the process of being filled at the minute.

DR. MAXWELL: Did the role change at all after the last post holder left, retired? 15:01

A. Not that I'm aware of, but that would have been sort of taken forward by the Director of Nursing and Allied Health Professions. Again, I could find you detail on that if it had. 15:02

DR. MAXWELL: Do you know if the current post holder is involved in doing any work with Muckamore at the moment?

A. Not that I'm aware of.

DR. MAXWELL: Okay. Thank you. 15:02

CHAIRPERSON: Okay. Well, look, we'll leave it there. Thank you, obviously, for coming to assist the Inquiry. I'll just say it may be of value -- the transcript, as you know, is published on our website, so it may be of benefit for you to review it and see the particular 15:02 areas that the Inquiry have demonstrated an interest in.

I should say this: If you wish to - there's no requirement - but if you wish to produce a further 15:02 statement, obviously then we'd be delighted to receive it. Otherwise, the danger is you come along and you get asked a lot of questions like this --

THE WITNESS: Okay.

CHAIRPERSON: -- when we need further information. But it is entirely a matter for you.

Thank you very much for your attendance this afternoon and we'll see you back on 19th April. 15:03

THE WITNESS: Okay.

CHAIRPERSON: So we're not sitting tomorrow morning?

MR. McEVOY: 2:00 p.m. tomorrow.

CHAIRPERSON: We will be sitting tomorrow at 2:00 p.m., so we'll see everybody then. Thank you very much 15:03 indeed.

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 4TH APRIL 2023 AT 2:00 P.M.