MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 29TH MARCH 2023 - DAY 30

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THE INQUIRY RESUMED ON WEDNESDAY, 29TH MARCH 2023, AS FOLLOWS

CHAIRMAN: Good morning. Thank you very much. Just give me a second, sorry. 09:59

Can I just mention to everybody, a couple of days ago we had some problems with the electricity here. We're not expecting anything to go wrong this morning but if the lights do go out, don't panic, the emergency lights will go on and we will evacuate. But we're hoping that won't happen. 09:59

Mr. McEvoy, I think we are lucky enough to have Professor Roy McClelland this morning. 09:59

MR. McEVOY BL: That's right, Chair and Panel. Just by way of introduction, if I might, and just by way of a brief recap, last week on Days 28 and 29 of the Inquiry's hearing, the Inquiry heard from Mr. Alex Ruck Keene and Professor Roy McConkey who gave presentations setting the scene from a legal and policy perspective regarding the Framework of Mental Health Law in Northern Ireland and then the Public and Health Policy Landscape, which led to the establishment of the Bamford review and to the passing then subsequently by the Northern Ireland Assembly of the Mental Capacity Act 2016, parts of which are already in force, and other parts of which, as you heard, have yet to be commenced. 09:59 10:00

This morning the Inquiry's working Module 1 and its exploration of the Bamford Review and related developments continues with evidence, as you say, from Professor Roy McClelland.

10:00

The Inquiry will have seen that Professor McClelland had produced to the Inquiry a comprehensive statement with extensive exhibits. It begins at number 083 and following.

10:00

With that, I can ask for Professor McClelland to be brought in, please.

PROFESSOR McCLELLAND, HAVING BEEN SWORN WAS EXAMINED BY MR. MCEVOY, AS FOLLOWS:

10:01

CHAIRMAN: Can I welcome you, Professor McClelland. Thank you very much for coming along, especially since I know you are suffering slightly at the moment. If you need a break at any stage, just let us know and we will stop. But in the meantime I will hand you over to Mr. McEvoy. Thank you very much.

10:01

MR. McEVOY BL: You will have heard the Chair's injunction, Professor, if you do feel that you need a break at any moment, please don't hesitate to say.

10:02

Professor, as you know my name is Mark McEvoy, I am one of the Inquiry counsel. We met briefly earlier this morning.

By way of introduction of you, you are a consultant psychiatrist by profession and in that capacity you're employed by the Belfast Trust, isn't that's right? And you are also a Emeritus Professor of Mental Health at Queen's University Belfast.

A. I am.

1 Q. You're here before the Inquiry today because between 2022 and 2007, you were involved with what began as the review of Mental Health and Learning Disability Northern Ireland. Initially you were the Deputy Chair of that Review and then you assumed the Chair of that Review following the untimely death of Professor David Bamford in January 2006.

I indicated before you joined us, Professor, that you have very helpfully produced a comprehensive statement of some 31 pages and then a significant number of exhibits. The questions that I have arise from the statement itself, but before I do that I wanted to ask whether you had the opportunity to see the two presentations that were delivered to the Inquiry last week on Monday from Mr. Alex Ruck Keene, and then on Tuesday from Professor Roy McConkey?

A. I did indeed, I saw both of them and I found them excellent.

2 Q. In general terms, and before we develop the themes in your statement, is there anything that you would like to take the opportunity now to add or to comment on in terms of what you saw in those two presentations?

A. Well, I would appreciate the opportunity, if possible, of making a comment on a matter raised by Mr. Alex Ruck Keene in relation to the UNCRPD situation and also something that Roy McConkey raised in relation to the funding expectations from the Bamford side that came up in his presentation from a question put to him by a member of the Panel.

3 Q. Yes, it is likely that we'll touch on that in the fullness of time anyway. But if you want maybe just to touch on the issue that you mentioned in relation to the presentation given by Mr. Alex Ruck Keene KC, that might be helpful.

A. Well, it may take a few moments. I have committed my thoughts to paper.

4 Q. Okay.

A. So that the Panel, if they wish to have them, copies of these, I can make them available. If that's...

5 Q. Well, we haven't seen the document in question so perhaps what we'll do is we will maybe consider that at the end. I'm taking you out-of-your course slightly, but if there's anything you may want to say by way of summary at this stage, that might be helpful, just in a sentence or two?

A. Well, I think that the legislation that we have probably has a kind of robustness in relation to the UNCRPDs expectations around the substitute decision-making requirement. But the second thing that really needs to be considered in a little more thought is that we're not dealing simply with mental capacity

legislation, what we have is fusion legislation. In any jurisdiction in which the UNCRPD is questioning the adequacy of the Mental Capacity Act, there is sitting in parallel a Mental Capacity Act in each of the jurisdictions and each of these is rounded on substitute decision-making. So there is an issue around whether you can completely remove substitute decision-making.

6 Q. Well thank you for sign-posting that at this stage. It is certainly a thing we'll come back to towards the end of this evidence session. 10:06

If I can just take you to the substance of the statement that you provided. You very helpfully broke your statement down into headings. At the outset, I think I've given a very rudimentary description of your background and your professional qualifications and so on. Is there anything that I have missed there? 10:06

I based your introduction on what you tell us about the Bamford Review generally. Is there anything you wish to add? 10:06

A. That's fine. That's fine by me.

7 Q. We're told in your statement that during the Bamford Review, Muckamore Abbey was one of three hospitals in Northern Ireland caring for those with a learning disability. You mention the others then as Longstone and Stradray. I'm at paragraph 7. You said in 2003 when the Review began, there were around 455 people living in hospitals. You break the numbers down as 10:07

follows:

- 300 in Muckamore.
- 115 in Longstone and;
- 40 in Stradray. 10:07

You then tell us that they had done so, on average, for 20 years and had an average age of 49. Pausing there, to the uninitiated lay person like myself that might seem surprising. Is it that length of time and life 10:07 experience or amount of life experience to be spent as an in-patient?

A. Well, this was a phenomena of Mental Health Services for years and then with the growth of the hospital provisions in learning disability, people with learning 10:08 disability were less accommodated in mental hospitals and more in the learning disability situation. So people spending many years in Hospital, society's way of coping in previous years was one very much of social exclusion and people whose behaviours were problematic, 10:08 and in the absence of modern methods of healthcare and social care, families had little resource. You have to think of the poverty of the background situation that people in the community would often be in in these situations. 10:08

So having a place of safety was sometimes a better alternative to the misery of some of their own personal situations and the difficulties people had coping and

without any support. So you had a massive growth in asylum over the 18th, 19th Century especially, late 19th Century, right into the 20th Century, and it is only in the mid-20s we begin to see this coming down.

As I say, recently in Northern Ireland the long-stay needs of people with a learning disability would have been met within the learning disabilities hotel structure, which were these three hospitals.

10:09

8 Q. That length of survey, that sort of average of 20 years, how did that compare to other jurisdictions on these islands, or are you able to comment?

10:09

A. I don't have first-hand knowledge at this moment, but intuitively it would have to be similar. This is not purely a Northern Ireland phenomenon. This is a western world phenomenon. It is the way we dealt with the more vulnerable, the intellectually disabled, the mentally-ill, chronically mentally-ill over 100 years at least.

10:10

9 Q. I suppose we can understand a little bit more about that idea of social exclusion and people with either a mental health difficulty or a learning disability finding their way into Muckamore for a long time, or hospitals like it indeed. Was there a sort of lumping together of mental health need, patients with mental health needs and also then patients with learning disabilities during this time or during the period around which the Review began?

10:10

A. From my understanding we had a very full separation of

mental health services for people of the normal range of mental abilities in the mental hospital structures. We had this growth in provision for learning disabled people. People in learning disability in long-stay hospitals will include people who have mental health difficulties as well.

10 Q. Yes.

A. People with learning disabilities are more vulnerable to mental health problems. So per unit of their population they would have a higher prevalence of mental health need and some of these needs would be considerable. So a significant component of the learning disability hospital provision would have been a mental health provision for people with a learning disability. But a significant amount would have been for lesser issues and lesser mental health problems for which, in a more modern progressive social provision could be well-provided for in a much more normal community home-type setting.

10:11

10:11

10:12

11 Q. The Bamford Review, as we know, looked into mental health and learning disability. It is perhaps asking you to employ a bit of hindsight, and I might do that once or twice during the course of the morning, but was there a reason why, and you may have answered the question already, but was there a reason why the two areas, if you like, were dovetailed in that way? Then I suppose a corollary of that might be --

10:12

10:12

A. Should it have been.

12 Q. -- should they have been, exactly?

A. Yes. I think, my understanding of the history of this is a group of us from The Royal College of Psychiatrists began a review of the mental health legislation, which of course to people of mental health and people with a learning disability. We put together a report recommending reform and modernisation and asked the Department to consider review of legislation. That was in 2001 we submitted that. The Bamford Review was commenced in 2002 and it said it should be a reform and modernisation of services for people with mental health needs and learning disability needs and a review of legislation. I think that was a very sensible thing to take services and legislation together. 10:13 10:13

13 Q. Yes?

A. Because you can't have one step forward without the other. So in that sense they were more insightful than we were simply saying let's look at legislation. 10:13

I think there is a tension in trying to marry efforts modernising mental health services and modernising learning disabilities services. There are share issues, stigma issues, for example. But a major thrust of mental health is services to deliver better treatment and interventions in a range of settings as accessible to people as possible or else a major thrust of learning disability is normalisation and helping people to live fuller lives. 10:14 10:14

I think there was a natural sensitivity within the

Equal Lives Review that they would get overburdened with our pressure on service improvement and both David and I were very sensitive to that and we gave them a very free hand to do their excellent work.

14 Q. Yes? 10:15

A. And it was one of several committees. That said, they were one of the first Committees to bring a report forward and I think they had the expectation that because they were learning disability, that their report would be implemented forthwith, whereas they had 10:15 to wait until all the reports came in.

15 Q. Was there a reason why that was so? Was there a reason why Equal Lives and its recommendations had to be stood over?

A. I think it can be defended in the sense that I think 10:15 there was a tremendous breadth to what we were coming forward with and we had done our best to cost it. But until you put the whole thing together, you didn't really know what we were asking for. I think for the Department to try and go to the Assembly with a bid, 10:16 not knowing what was coming behind it, and not knowing what priorities to give what and how to face it, I think it would be very difficult to move the whole thing forward in bits. So I think there probably was a justifiable reason for holding fire until an action 10:16 plan could be based on the whole schema.

16 Q. Was that driven by a concern that it might have been difficult to get all of the funding, the money, in place or am I being unnecessarily narrow there? Were

there other considerations at play above and beyond money?

A. I can't be sure what was in the Department's mind, but at the very least they had to make a bid and that bid had to be justifiable and justified. So they needed an evidence base to make a bid for an uplift in what was -- in what was then that that comprehensive spending Review that mental health and learning disability would be given a priority. 10:17

17 Q. But they had to go together? 10:17

A. It would make a better case if they could see the enormity of what they were asking for.

18 Q. Again I'm asking you to employ hindsight, I accept that, but we know now and looking back on circumstances with 2003 eyes that there's a clearer understanding that, I think, you've hinted at it, that mental health can often, and related needs and issues, are often, not always, but often more acute and urgent in nature. Whereas, as you averted to, learning disability is whole life, people with learning disabilities have needs that are lifelong and cover the entirety of their circumstances. So they are coming from two quite different directions. 10:17 10:18

But we can see then that when Equal Lives, which was the focus, if I understand it correctly, of the reviews working on learning disability it took its place as only one Committee then among a number. I'm not seeking to minimise it, but it took it's place as one 10:18

of a number of work-streams they the Review had.

Might there have been a case at an earlier stage for saying the enormity of learning disability and related needs and the fact that people are spending so much of their lives in hospital requires us to go back to the drawing board at an early stage and examine learning disability and related needs separately? 10:18

A. I think a case can be made. I was conscious of the tensions at the time and I think a sense of disappointment coming from colleagues in learning disability that there would be a delay. I think it would have been difficult for the Department to kick-start one, for the reasons I've given. 10:19

CHAIRMAN: Can I just ask so that I understand this: The Bamford Review I think started effectively in 2002. 10:19

A. That's right.

CHAIRMAN: The Equal Lives Report was in 2005. The last report was the Reform and Modernisation of Mental Health Services which was published in 2007. Was that the last report? 10:19

A. Well Social Inclusion Report. I think the Social, I've forgotten the name of it. Our legislation report was 2007, there was one other report came in from that.

CHAIRMAN: Are you saying that the wheels of the Department couldn't start turning until this last report was in? 10:20

A. Can you...

CHAIRMAN: That the Department couldn't start moving on

any of the recommendations in any of your reports until the very last report was in, is that what you're saying?

A. I'm noting that that was what happened and that was their decision. I think it has a defence of the kind I have tried to present on its behalf. 10:20

The equity issues, for example, the Adult Mental Health Report, which I chaired, came out, it was the first report, it came out just shortly before Equal Lives. We didn't ask, for example, that adult mental health should be taken forward as a first priority. We knew we had to wait until children and elderly were considered. 10:20

CHAIRMAN: I'm not, and this is not meant to be critical, it is genuinely meant to simply understand and what you are saying is that until the Department could see the whole package, the bid, as it were, couldn't be made? 10:21

A. I think so. 10:21

CHAIRMAN: I see. Okay.

A. I think it's defendable. But I can understand the passion on the part of people with learning disabilities seeing they got hooked with us. I think the counterargument was, I think we had a momentum created by the sheer force of the two processes together and the budgetary bids ultimately for the two are not so dissimilar. In fact, the mental health side is slightly larger and then there was health promotion 10:21

and legislation again. It's about managing change across a big sector.

19 Q. Yes. I suppose that's what I was sort of hoping to get your illumination on, given the size of the task was there consideration at any juncture to saying this is so enormous that it is going to require its own separate review or examination, or was it always going to be a situation where the two had to return together. I think what you are telling the Inquiry is the latter was the case for a number of reasons, most of which are financial in nature? 10:22 10:22

A. Yes. And I think another issue that I think will come up again and again is the infrastructure issues, like workforce.

20 Q. Yes? 10:22

A. Not just costings. We needed a workforce strategy and I think it would not be logical to have a separate workforce strategy. The agenda was similar, training and supervision, support, change of profile, retraining staff. So I think there's a justification if you think of the infrastructure side. 10:23

21 Q. Maybe an opportunity to discuss the workforce strategy, actually, in due course, in the course of the morning, Professor.

10:23

In terms of your section headed "The Overview of the Bamford Review and Subsequent Developments", there's quite a bold statement at the outset of paragraph 10 where you tell us that the reality is that if the

proposals from the Bamford Review have been implemented then Muckamore Abbey Hospital would not have existed in 2017, other than as a potentially small acute assessment and treatment facility for which there were always, in all likelihood, be a requirement in Northern Ireland. As you point out then, Recommendation 27 of the Equal Lives Review in June 2011, all people living in a learning disability hospital should be relocated to the community. 10:23

10:24

The reason why I suggest it's bold is that there are a number of things that I would welcome your comment on for the Inquiry's purposes. Was there any active cognizance on the part of your team, the whole team or as far as you're able to speak to it the Equal Lives team, to a risk, heightened or otherwise, of abuse in a hospital such as Muckamore? 10:24

A. My impression, and I think I picked this up from Roy McConkey who has a much greater depth of appreciation of the Equal Lives situation as an expert. 10:24

22 Q. Yes.

A. There was some acknowledgment but it was not a major issue on the agenda and there are one or two references in the Equal Lives Report to abuse of potential risk situations. I think it refers to children and home situations. But the issue of needing to move to the community to prevent abuse and to get that moving in 2005 wasn't a lever or an argument. 10:25

23 Q. Yes, or as a driver as sometimes the jargon has it.

The Inquiry might be interested to know whether there's a reason why a risk of abuse or potential for abuse to arise in a hospital such as Muckamore wasn't on the radar, either of the totality of the Bamford team or of the Equal Lives Review in particular? 10:25

A. I'm sure experts in learning disability, as in mental health, are aware of abuse. I don't think it was, I mean given the many, many conversations we've had, there was any belief that the status quo was a major source of a problem that was around us in terms of a 10:26 potential abuse.

24 Q. Can you explain that a bit more?

A. The dominant agenda was improving the quality of lives, it wasn't preventing bad things happening.

25 Q. Yes? 10:26

A. It wasn't that there was, you know, an ongoing sense of bad things are happening in our mental hospitals, in our long-stay mental hospitals, because long-stay is long-stay, or there's bad things happening in our hospitals. The problems with these institutions is 10:27 institutionalism and the lack of normalisation and quality of life for people with long-stay mental health and long-stay learning disabilities. It is the same situation if you want to transform and normalise. It may be abuse in the sense it is social deprivation -- 10:27

26 Q. Yes, it takes a number of different forms, of course. Yes.

A. But it's not physical abuse or sexual abuse, active abuse, it is passive abuse in the sense that people are

just left to stay in large numbers, in large wards, without proper social activities.

27 Q. Yes. So, I mean, as far as the Inquiry then can take it, while the term itself might not have been broad in your minds, are you saying that there was a cognizance of a more sort of institutional or, I'm just trying to get a sense of the awareness of risk that there was, I know you say that this was all about positive and engendering positive change and movement. But I'm just trying to get a sense of the extent to which there was any awareness of risk, nevertheless, of, as you put them, bad things happening? 10:27 10:28

A. If there were, it would be stated in the Equal Lives Report. I'm not aware of that in the Objectives or anything else. So I don't think it is a major factor. And it wasn't mine in the sense that I Chaired the Adult Mental Health side and it wasn't a factor in driving us for change. So we were dealing with long-stay as well as all the acute. 10:28

28 Q. I began my questions just on this particular issue by describing your statement at the outset about the reality of the implementation of your proposals in terms of Muckamore leading to its closure. One of the reasons why I said it could be described as bold is because, presumably, there would have had to have been a process of public consultation in relation to the Bamford Review. Was that a factor that was in your team's thinking that, you know, we're coming up with these proposals, huge amounts of paperwork, huge 10:28 10:29

amounts of detail, enormous numbers of very detailed recommendations, but the Department are going to put this out to the public at some stage. Was there a cognizance and an appreciation of that?

A. I believe so. One of David Bamford's great achievements with the Bamford Review was this inclusivity. He really ensured participation from a very wide range of stakeholders. The Review itself I think cost over £1.5 million pounds. It was because of that broad inclusivity and able to use the resources to get that, that I think a lot of the consultation work was created in the very Bamford Reports themselves. 10:29 10:30

So the Department had a very comfortable situation if they went with the Bamford Review and what you tend to find with the discussions the Department was having with the Assembly was a kind of acceptance and a buy-in to Bamford. It was known as the Bamford Proposal and the Bamford Review and that language became quite conversational. There wasn't a big sell. A lot of the connectivity with the community, particularly the service users and their families, they were onboard, they were part of the process and they were strong voices. But there was consultation. 10:30 10:30

29 Q. In terms of the make-up of the Review Team itself, I think you listed in your statement, I think there were 22, correct me, there might be 22 members drawn from all sorts of backgrounds, professional experiences, the police, clinicians, so on and so 10:31

forth. Were there any actual, or was there any input, I know in Equal Lives there's reference made to a User Group?

A. Yes.

30 Q. But what was the extent of the input in terms of the Review Team itself from people with learning disabilities, just picking up on that inclusivity thing? 10:31

A. Yes. Are you referring to the Equal Lives Committee?

31 Q. The Bamford Review itself more broadly, if you can? 10:31

A. We had service user representation and carer input to the Bamford Review. I know we had a mental health service user. We had Joanne, yes, she was a learning disabilities service user, she was on our Committee. And we would have had a family member at least from 10:32 both mental health and learning disability and they were all connected to their support organisations that were in the respective bits of the Review. I say that's all to David's credit, it was a very inclusive process. 10:32

32 Q. Nevertheless, you continue by telling us then in the fullness of time --

CHAIRMAN: Can you give us the paragraph? Can I just say, my transcript isn't working, I don't know if anybody else's is, it's extremely frustrating. 10:32 I raised this with the Secretary to the Inquiry. So apologies to everybody. There will be a transcript at the end, I assume, that we can actually save but it means that nobody can mark-up what's happening. So it

would help us, I think, Mr. McEvoy, if you could take us to the paragraph number that you are referring to. I know we also have the facility to put that up on screen.

MR. McEVOY BL: That might be helpful, if that can be done. 10:33

CHAIRMAN: So if you can give us the paragraph number again?

MR. McEVOY BL: I was at paragraph 10 which is where we just left and then we are moving to paragraph 11 then, which will be on 083-3. 10:33

CHAIRMAN: Once we get it up, and there we go, right, that's going to help everybody. Thank you.

MR. McEVOY BL: We just touched on paragraph 10, if we can move down to paragraph 11. Thank you. 10:33

You tell us in 11 then that central Government and the Department did not or was not able to make available the required financial resources and to properly, effectively, and fully implement the comprehensive proposals that were developed through the Bamford Review, which would have seen services fundamentally reshaped so people did not live in a learning disability hospital. 10:34

10:34

You mentioned then the interview you did with the because about that and your description of it as a "chronic disappointment". Can you venture a reason, you have made your observation plain there, but can you

venture a reason or an explanation as to why the resources weren't forthcoming?

A. Yes, I can.

33 Q. Now is your opportunity to venture it.

A. Can I refer to my own notes because they are... 10:34

34 Q. We don't have the notes available. We'll take them in due course but nobody else has seen them, Professor, so we don't know what it is you are referring to?

A. I need to guide my thinking.

35 Q. I defer to the Chair, but it's not usual. 10:35

A. I see.

CHAIRMAN: I think if we can keep going as we are at the moment. Any notes can be distributed. Everybody has to be able to see them.

36 Q. MR. McEVOY BL: Thank you, Chair. I appreciate you may not be able to give an enormous amount of detail, but if you want to give us -- 10:35

A. I'll speak, the notes are there, they give a more thorough.

37 Q. If you can summarise that would be very helpful. 10:35

A. Yes indeed. The Department's Action Plan for 2012 to '15 is a very useful document because it provides a review of the progress-to-date for the first phase of the implementation. That's the '8/'9 years through to '10/'11 years, the three years. In that they state 10:35 that there was additional funding identified for learning disability totalling £17 million. However, by 2010/'11, the effects of the public sector funding crisis was starting to bite and the amount committed to

learning disability was reduced to 12.

However, very helpfully, they go on to say that the Trust's actual spend on learning disability over that first three-year period was considerably more and totalled £39.88 million. That was a very welcome priming of reform and modernisation. 10:36

They go on to say in the 2012-15 Action Plan Report:

"However, the problems with funding remain severe and that for the forthcoming Action Plan period the amount available for learning disability is £6.9 million." 10:36

For me, that was a catastrophic drop. It wasn't just a low investment, it was a drop. And if I can use the analogy of a train going up a hill out of a station, the Bamford train had moved and it was running out of steam, it was running out of fuel and was at risk of not only coming to a stop but its own breaking power would be slowed up and the risk of going backwards. I mean this was a very bad stressor on the system. Only part of the stressor, I should add, but that was the financial component of the stressor. 10:37 10:37

Combined with that was the Department's exclusive requirement that that funding would be used exclusively for resettlement. While on the one hand that might sound a relief that at least it would deal with some of 10:38

the resettlement issues, the problem is that there was no more money to do anything with anything else, including the development needs of in-patient settings, including Muckamore Abbey itself.

38 Q. I was about to ask you what the implications of that were, so the resettlement money was to be used once patients were outside the confines of the hospital? 10:38

A. Yes. Yes.

39 Q. So what was the predicament then for people inside it, I think that's where you were going? 10:38

A. Indeed so. The predicament is the predicament for management. I have to refer to a document that's in my notes. Do you mind if I actually refer to it?

CHAIRMAN: No, no, of course you can. We'll see them in due course. 10:39

A. This gives a measure of the commitment, positive commitment that is from the Northern Ireland Housing Executive. This is a report to the Northern Ireland Housing Executive entitled: The Hospital Resettlement Programme in Northern Ireland after the Bamford Review. 10:39

CHAIRMAN: Is this not one of your exhibits, no?

A. It may not be.

CHAIRMAN: All right.

A. I'm quoting from this, as follows, at paragraph 2.2.5: 10:39

"Participants in the consultative interviews that took place as part of the research said that the new resettlement plans and new structures agreed in 2011 and starting on 1 April 2012 were critically important:

1. A new Performance Management Framework was put in place.

2. A revamp Programme Delivery Board was established.

3. Annual resettlement targets were set for each Trust.

4. Trust performance was monitored regularly and they were held accountable for meeting their targets. 10:40

5. Trusts were required to make a monthly progress report to the Board.

6. Progress was reviewed by the Programme Delivery Board with reports to the Minister." 10:40

Now that's very good for the output end, for the people who were going into the community, but you can imagine the Trust's attention. There's no funding for anything else and there's an intense performance management framework about delivering the outcome on patient delivery. 10:40

So while they were trying to settle patients, the likelihood was that there would be very limited attention paid to the in-patient setting and the welfare of patients while you're doing all this, getting patients into the community. If you're not on 10:40

that boat out, there's a problem.

40 Q. Indeed that's something you say, and perhaps just moving down to paragraph 12, if we can? The second and third sentences, in fact. Something that you have, I think, foreshadowed with what you have told us. The Inquiry will, no doubt, want to consider the effect of running a run a learning disability hospital whilst at the same time resettle from it the patients who reside in, and further, the Inquiry will also want to consider the affect of the process of resettlement where the most complex patients are those that are left behind to be cared for in the learning disability hospital. 10:41 10:41

You volunteer your assistance in terms of wanting to explain, or being prepared to explain a bit more about what you mean by that. I mean, picking up on that theme of what the implications might be for those left behind in the hospital, you've said that those are or were some of the most complex patients? 10:41

A. That's correct. I mean, as well as the intentional factor on management, there's the change in the milieu. 10:42

41 Q. So, can you tell us a bit more about what you mean by that? The Panel Members will understand obviously, but the layperson may not. So maybe if you can explain that in a bit more detail that might be very helpful. 10:42

A. When one's doing resettlement work, typically it's simplest to start with patients with the least complex needs. They're easier to resettle and the options are available, so the whole thing moves more easily.

That's a process that just keeps working its way through until you have fewer and fewer people needing to be resettled. But as you go down through that process, it's not an alphabetical list, it's a list of complexities. You're dealing with more people with greater needs and these needs will typically be in the mental health sector, people with mental illness, schizophrenia, severe autism.

42 Q. So we're clear, these are people with learning disabilities but may also have a mental health need in addition? 10:43

A. Oh yes, yes. And this will include behavioural problems, much more severe. You're getting a concentration of this. I think it's also worth noting that the staffing of learning disability hospitals is by learning disability nurses, they're not mental health nurses. They are not really trained as mental health nurses. So the skill mix is not necessarily optimal for this kind of situation. So unless there's a training programme moving the needs, addressing the needs of staff to meet the needs of the patients, then there is risks of mismanagement. 10:43 10:44

43 Q. Yes. That is a little bit earlier why I mentioned to you the concept of risk awareness within Bamford. When we get to this point in time in which you gave the interview to the because, I'm not just asking about it, but the concerns that were broad in your mind at that time, was there, to your knowledge, an effort on the part of the Trust to go to central Government and say, 10:44

we have an issue here, we are able to resettle the people with the least level of need, but as a matter of almost logic, we're going to be left with the most needy patients in, if that's a word, in the hospital. What are you going to do to help us because there are going to be issues? Was that message transmitted to central Government?

A. I wasn't aware of that message going back up to Government. I mean, the direction the Department was giving was quite clear and the Performance Management Framework that I referred to gives you a feel for the sense of direction and the Department's exclusive allocation of any funding. It wasn't saying you must be aware to use some of this funding for back-up because the consequences of what we're trying to do. So I don't think there was the insight in the system at the time. You could say even Bamford failed to have reflected on what could happen if things go wrong. So I'm saying there's a responsibility backing up on all of us here. Could we have foreseen this? We were looking forward but we weren't looking over our shoulder at "what if."

44 Q. Yes. On the nursing issue, you had mentioned that learning disability nurses deal with patients with learning disabilities. I suppose in the ideal world mental health trained nurses deal with those with those with mental health needs. Do you know, if you don't know, if you're not familiar with the detail, but do you know what the picture was in Muckamore at that time

or what the impression at the management level was of what was being done in terms of the provision of adequately trained nurses or appropriately trained nurses according to need.

10:46

I think Dr. Maxwell may have a question on that issue.

MR. MAXWELL: I think on this question about nursing you make a very good point, but I think it could be argued the mental health nurses don't understand learning disabilities so what actually is needed is a duly trained nurse. 10:46

A. That's exactly right.

DR. MAXWELL: I know you are going to come on to the workforce plan because I haven't seen it mentioned there, but I suppose the question you're asking what I would like to drill down to is, do you know if there were any duly trained LD and mental health nurses at Muckamore? 10:47

A. I know talking to one of my consultant colleagues who was working in Muckamore Abbey as a consultant up until about 2009 until she retired, she worked quite hard involving colleagues in bringing training into nurses. Like, Lord Alderdice used to do psychotherapy training with some of the staff. So they skill them up in the mental health field, but as far as I can see there wasn't a formal dual trained nurse calibre in the system formally at that time. 10:47 10:47

DR. MAXWELL: It's my understanding that neither of the Universities do a shortened course. So, for example,

if a registered nurse wanted to train as a midwife, it's a shortened course. I'm not aware in Northern Ireland of any way that a mental health nurse could do a shortened LD course or vice versa.

A. Yes, a work strategy would have been an issue to look into this, wouldn't it? 10:48

DR. MAXWELL: I know you are coming on to that later.

MR. McEVOY BL: Dr. Maxwell was going exactly where I was going in terms of a practice working of one of the messages; the Trust, that is to say, might have transmitted back to the Department which is to say, you know, there are going to be pressing needs if we are left in Muckamore with patients with the greatest level of need. One of the practical needs we may have is a need for duly trained nurses. 10:48 10:48

A. Yes.

45 Q. But I think we can take it that that message, and we don't know whether it was transmitted but we certainly...

A. I know nothing of it. The silence is... 10:48

46 Q. Again, hindsight is 2020-vision, but would that have been a very practical message that might have been appropriate to have transmitted?

A. I would have thought in an ideal world that the Department flagging the risks and making sure some allowance was made, the funding crisis created a problem for everybody. 10:49

47 Q. Yes?

A. I mean it slowed the process. So the assumption was

that by 2012 most people would have been out of hospital. So it was almost over before any issues could have arise, it was happening. I think it was to get it out, get people moving quickly.

48 Q. But as we know, although in terms of numbers, there was a reduction in numbers of bodies, that is to say of patients, was not the same as the level of need and the imperative to ensure that the need that was -- 10:49

A. That's right.

49 Q. -- the need be met for those remaining? I was going to ask, and maybe we will just clarify the point in terms of paragraph 16, you discussed the Terms of Reference. If you come down to 16 there. I had asked you about the inclusivity. If you look halfway down the paragraph you say: 10:49 10:50

"Widespread consultations with stakeholders endorsed our vision on the strategic direction of the review. A feature of the review process...".

CHAIRMAN: Can you slow down a little bit please, otherwise the transcript is never going to be right. Sorry, I know you are reading.

MR. McEVOY BL:

"Widespread consultations with stakeholders endorsed our vision on the strategic direction of the review. A feature of the review process was a contribution of users and carers across both mental health and learning

disability. Their insights, advice and guidance were very important. The recommendations that we made for service reform were underpinned by a sound economic appraisal carried out by our Needs and Resources Committee." 10:51

We have touched on the inclusivity in terms of the nature of the Review and the people that it heard from. In terms of the economic appraisal, I think earlier on you indicated at the outset that this was something 10:51 that you were concerned to respond to and what professor McConkey said to the Inquiry last week. One of the points that was made to Professor McConkey and it came from Dr. Maxwell was about staffing costs and support staff and, you know, the economy of 10:51 staffing costs and having larger facilities. The question was really around whether there was an examination of the ongoing revenue costs of staffing.

Professor McConkey said that he, in retrospect, said, 10:52 and I'm summarising, he said that in that respect and upon reflection that if he were asked what were some of the shortcomings of the Equal Lives Review, he thinks there was insufficient attention paid to value for money. He said that in that respect the costs of the 10:52 long-stay hospital, any evidence we could gather on those costs and, indeed, it was very hard to extract from the Trust how much money was being spent on long-stay accommodation. This was something that was

in his mind.

A. Yes.

50 Q. Is this something on which you have a view having heard that, and given what you say about the underpinning of the Bamford recommendations by a sound economic -- 10:53

A. Yes, indeed, I would like to comment on that. I think the impression Professor McConkey, for whom I have the highest regard, may have given, perhaps unintentionally, that there was insufficient attention being given to the costs of what we were trying to do 10:53 and sort of, by implication, that we were at risk of creating a wish-list.

While our estimates of the recommendations individually and cumulatively for the Equal Lives Report may have 10:53 been inaccurate, we did give the matter very serious attention. I think in support of that view, I would like to draw the Inquiry's attention to the Strategic Priorities Report, which I do think you have.

51 Q. I think if I can, hopefully, maybe get it pulled up on 10:54 screen, it can be found at 1477, hopefully.

A. Thank you very much. At page 24 --

52 Q. Internal page 24?

A. Yes of that, we provide a section on infrastructure issues. 10:54

53 Q. That page there, Professor?

A. That's it, yes. It states there that:

"The Review, as a whole and its first phase, depend on

a number of underpinning elements and processes."

At page 25 we note that:

"The proposed Programme of Modernisation and Reform has significant implementations for revenue and capital." 10:55

Then at page 25, sorry, 26, we propose --

CHAIRMAN: Hold on. Let us just find it so that we can actually see it on the screen. Can you see the screen yourself? 10:55

A. I can, indeed.

CHAIRMAN: It says "we propose".

A. Yes, "we propose", there it is:

"We propose as a first step to fulfilling the vision for services as set out in our reports that an investment strategy be agreed by the Northern Ireland Assembly and/or direct rule administration." 10:56

I should add that in the course of Bamford through to implementation phase of the legislation of 2016 we had six changes of Minister to deal with, including, I believe, two Direct Rule Ministers. So the situation in Government is not insignificant in this process. So we had to keep saying, whether it would be the Assembly or a direct rule administration: 10:56

"...address the present funding gap, to pump prime the

reform process and to provide Northern Ireland with the resources needed to achieve equivalence with the other jurisdictions."

Then at the very end, at the very last sentence: 10:56

"An analysis of the issues and costings of the Bamford Review are presented at Annex 10."

Can I take you to Annex 10 at page 139, internal page 139. 10:57

MR. McEVOY BL: Just bear with us for a moment, just while we get it.

A. Thank you very much. This is described as "The Costs Needs and Future Investment". This piece of work was 10:58 carried out by a Needs and Resources Committee. Bamford established this. So we had this aspect of the infrastructure of the Review taken care of by people considered in their own field experts, Board Officials from the Trusts, people with a knowledge of accounting 10:59 in the Services and how to cost services, because we were not capable of costing it ourselves.

So at paragraph 1.2 it states here that the remit of the Needs and Resources Committee is to investigate and 10:59 report on the following:

"Current funding for health and personal social services for mental health and learning disability.

Impact of need and resource allocation formula.

Spending by other Government Departments on mental health and learning disability."

10:59

Fourthly, most importantly:

"Costs of the recommendations of the Bamford Review."

In parenthesis it states: 10:59

"(By agreement with a Steering Group for the Bamford Review, the remit of the Needs and Resources Committee was extended to look at issues associated with the requirements for additional investment in services)." 11:00

Further down on that page, at 1.3, it notes that in addressing its remit, the Needs and Resources Committee was conscious that a number of reports had already been produced. At 1.4 it states: 11:00

"These reports were submitted as evidence and taken into consideration."

At 1.5: 11:00

"The report summarises the recommendations of the earlier publications and provides estimated costs for the recommendations arising from the Bamford Review."

Finally, over at 1.6 on page 140:

"Any comparative investment figures referenced in the report were correct as at 31st December 2006."

11:00

Now, what I would like finally to ask the Committee is to go to the Conclusions regarding disability funding. This is first based on comparative data at paragraph 2.30 at page 150.

CHAIRMAN: It is our 1627, I think. 11:01

A. If you go to 2.30, paragraph 2.30. That's it. Thank you very much. If I can just read this to you:

"Overall, the Northern Ireland spend on health and personal social services for learning disability should 11:01
rise by 20% to bring it up to the English per capita spend, and then be increased by a further 59% to take account of the differences in need, making a total requirement of an additional 79% uplift."

11:02

Okay. So that's based on a comparison with England and then taking account of our needs. But the second estimate they did was based on the actual recommendations of Bamford itself and these two figures need to be kept in mind. This is given just on the 11:02
next page, Table 7, page 151. You'll see the figure of £173 million. That is a 109% increase. The comparative figure is 79. It's significantly higher. The reason it's higher is that we weren't simply trying

to do what England had done, England was trying to improve its situation, we were trying to improve ours from a much worse baseline. So we were setting the standard as to where we wanted to get to and that was what we thought we needed.

I think the Needs and Resources Group did an excellent piece of work in trying to help us to cost what might have been seen otherwise as a wish-list. I felt that point needs to be clarified. We may not have got it right, but I think before we ever ran out of funding because we had underestimated, we ran out of money because of the public spending crisis, the public funding crisis.

54 Q. That figure of £173 million, I suppose to go back to the point about the consequence or the extent to which attention was paid to the emptying of the hospitals, Muckamore included, how much, was that a factor in the calculation of that figure?

A. Well, it was already impacting when you recognised £39 million had gone into the first three years.

55 Q. Yes.

A. That's well-on-target for this kind of figure. But that drops to 6.9. It's told you can only spend it on resettlement.

CHAIRMAN: Can I just understand what that figure really represents. I may be the only one in the room who doesn't quite understand. The total figure is £173 million going forward. But what period does that

cover, because you are talking about looking after these patients for X number of years.

A. Yes.

CHAIRMAN: Is this an investment figure?

A. This is a lift of the recurrent spend. 11:04

CHAIRMAN: Right.

A. So the spend around this time may have been around, say, two-hundred-million. Well, we know it is slightly less than that.

CHAIRMAN: Annual spend. 11:04

A. Annual spend. The 173 represents that 109% uplift.

CHAIRMAN: Right. And that you reckoned, in effect, as a Committee, would have met, or it would have allowed the Department to meet all of your recommendations in terms of learning disability? 11:05

A. There was our assumption.

CHAIRMAN: Right, okay. Sorry, I just needed to encapsulate that. Thank you.

MR. McEVOY BL: That figure is based on prices as indicated there in 2004 and 2005. Was there built into 11:05 that calculation what might happen to pricing going forward?

A. I can't be sure, I would hope so, but...

DR. MAXWELL: Can I just ask, you may be coming to this, but I think it is useful to ask now. The 11:05 £6.4 million for resettlement, I don't know how many patients that would be expected to cover. Did you have any idea of how many patients that would allow to be resettled?

A. Yes. With more complex patients, as you know, the costs are significantly higher. But I know, again, talking to my colleagues recently £80,000 per year, per patient, at least, as a basic starting point. So £6 million isn't a very large sum of money.

CHAIRMAN: Sorry, is that the care costs following settlement?

A. Yes. It is simply the care costs on the outside.

CHAIRMAN: Right.

A. With private sector provision as a dominant model, as we know it has become, it tends to be much higher. In the Winterbourne Review Inquiry I think it was £150,000 per patient.

MR. McEVOY BL: Presumably there's going to be considerable variability based on the degree of need?

A. Oh yes, yes. The more, as I say, you go into the more complex patients with greater care needs, the greater the costs.

DR. MAXWELL: So the £80,000 is for a lower needs' patient?

A. That was a 2009 estimate that I was given recently.

DR. MAXWELL: Right, that was 2009.

A. Yes. By 2012, when this is being talked about and we're down to 6.9, that money, that level would probably have gone up quite a bit.

CHAIRMAN: Is that for a lower needs patient? Is that for a patient who needs one-to-one care or...

A. I was understanding in 2009 the typical patient being resettled at that time, which would have been a

relevantly low-level of need, there were over 200 in long-stay care at that time, I think there was more, I think there was nearer 400.

CHAIRMAN: Right.

A. Just settling them would cost £80,000. 11:08

CHAIRMAN: Okay. I don't know if you are moving on or staying with that, because we have been going about an hour and ten minutes.

MR. McEVOY BL: I was just going to propose a break before I move on. I have a slightly different area to 11:08 cover now, so it might be an appropriate moment for a brief comfort break.

CHAIRMAN: Okay. Thank you very much indeed. We'll take a short break. Again, if you need to discuss your evidence with Mr. McEvoy, please do, I know he will 11:08 tell us what the result of that discussion was. Thank you.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

11:31

CHAIRMAN: Yes.

MR. McEVOY BL: Thank you, Chair. We were looking at some financial matters and money related matters, and no doubt, given the nature of this Inquiry, we will probably touch on them again a bit later on in the 11:31 morning, Professor.

I wanted to move on, because in your statement, as I said at the outset you have very helpfully broken it

down into a number of headings, and in the next section you deal with the Equal Lives Report and you dedicate quite a bit of detail to it. I wanted just to turn to what you said at paragraph 28. Well, really, it is just citing one of the conclusions which are set out in the outset in fact of the Equal Lives report. If you look at 28, it's the conclusion essentially or the Executive conclusion. 1.11: 11:31

"People with a learning disability in Northern Ireland do not enjoy equality of opportunity and are often excluded from the opportunities that other citizens enjoy. Their families frequently often suffer high levels of social disadvantage and their caring requirements responsibilities can place them under almost unbearable levels of stress. There is evidence of progress having been made, but in order to fully tackle these difficulties there is a need for major coordinated developments in support and services and a continuing change in attitudes over at least the next 15 years. We believe this will best be achieved through the adoption of a shared value base, a focus on shared core objectives and rigorous efforts across Government Departments and Agencies in the community to implement a change agenda that is detailed in the Equal Lives review." 11:32 11:32 11:32

Would it be fair to describe that as something that was or ought to have been a watershed moment for persons

with learning disabilities in Northern Ireland?

A. Yes, indeed. Again, Roy McConkey last week, I think, conveyed the spirit of enthusiasm and general uplift that everybody felt from not just the work, but the way it was worked, the inclusivity and the sense of togetherness. I felt it myself when I met, as I often did, with the Groups at various events. So it was a moment of great hope.

56 Q. I was about to ask you whether you shared the sense of optimism that he described when the report was published? 11:33

A. Yes. I mean this, across the Review, there was a great sense of hope. Not -- hope is not all lost by the way, but it was a great moment.

57 Q. Yes. You go on I think, and if you bring up paragraph 32, you go on to describe and mention, and make reference to a report from the then Department of Health and Social Services from 1995. The reference that is made to it, indeed, in Equal Lives Review. If I can just read out, maybe, the conclusion or the excerpt, sorry, from the Equal Lives Review which is included. It is 3.9. So it appears at the bottom, sorry, just midway through really. Page 32, yes. 11:33 11:34

"It should be noted, however, that much of the evidence presented to the Learning Disability Working Committee indicates that these aspirational statements have not been fully translated into practice. In particular, the review of policy and services for people with a 11:34

learning disability 1995, pointed the way towards many of the changes that we are again highlighting in this report. The failure to fully implement the recommendations of that Review appears to stem from a combination of the following factors." 11:35

So although the Equal Lives Review is published with a sense of optimism and hope, there is a recognition that there has been an attempt at a Departmental level to at least look at these issues before, this is about 10 years beforehand. 11:35

A. That's right.

58 Q. And there is a failure, an acknowledged failure, that the Equal Lives Review notes.

11:35

Now, in due course the Panel will, obviously, want to consider how that might have impacted on matters within the terms of reference. But the factors that you have set out in the bullet points within 32, paragraph 32 there, the bullet points from the Equal Lives Review itself. Can I ask you for your comment, if I can take you to them in turn and any comment you might have in relation to each of them. The first one is: 11:35

"Insufficient resources to build up the community infrastructure, including community-based alternatives to hospitals required to deliver on the strategic intent." 11:36

Is there anything you would say about that?

A. The need was very obvious. For those already living in the community there was a lack of resource to support and enhance their quality of life, their inclusivity. The absence of those supports led to greater isolation and lack of equality and experience. So that Group, which is the larger group, of course, already in the community, are the people living in hospital with more complex needs needing additional resources to help them in the community. We talked about the kinds of costs involved. So having cost the amount, roughly, hopefully, semi-accurately, you get a sense of the resource need and the insufficiency at that point there. 11:36 11:37

59 Q. The next factor that is mentioned is: 11:37

"A lack of robust implementation mechanisms to hold all Government Departments and Agencies to account for their actions in implementing the recommendations." 11:37

Is there anything you would add to that?

A. Well the need for a coordinated implementation plan was so obvious, that was one of the reasons we had this priorities document, to spell out some of the infrastructure issues, resourcing being only one of them. Only the Department could lead on that. 11:38

60 Q. Yes.

CHAIRMAN: Can I just ask, did you work out any system as to how to hold a Government Department to account

for their actions in implementing any recommendation? I mean, how is it actually done because this is a constant refrain, I think, of reports and enquiries.

A. This must be the $64,000 question.

DR. MAXWELL: I can add to that, on page 1581 there was a requirement to set up a Regional Implementation Steering Group for Equal Lives. Did that get established and did it hold any -- 11:38

A. I'm not aware of it.

DR. MAXWELL: You don't think it was even established, even though it was one of the actions? 11:38

A. No, no. I think that was aspirational. It never got off the ground. But holding the Department to account, and across departmental account, I think this is a very, very important issue. 11:39

CHAIRMAN: I understand the complaint. I wondered if you found a solution, you didn't?

A. I beg your pardon?

CHAIRMAN: I understand the complaint you were making, but I wondered if you found any form of solution. 11:39

A. No.

CHAIRMAN: No. Thank you. Sorry to interrupt, Mr McEvoy.

MR. McEVOY BL: The next factor is something that we have perhaps touched on already, but: 11:39

"The continued perception that the needs of people with a learning disability can be met solely by Health and Social Services."

A. Yes. Well I think this touches at the heart of the values base of Learning Disability Initiative in the Equal Lives Report. The whole normalisation, people using normal housing, aspirations of some sort of useful use of time, even employment opportunities, recreational opportunities, these are all things outside health and social care. If you are looking for an across-government response, the funding we were referring to of course is mainly in the health and social care domain, so there are issues there. 11:40

61 Q. Finally, then:

"An underdeveloped culture of involving people with a learning disability and family carers in determining the services available to them." 11:40

A. Yes. Yes.

62 Q. Self-evident, is that --

A. Self-evident.

63 Q. Okay. So the conclusion then on that particular portion of the Equal Live Reviews is that: 11:41

"The challenge for the future will be to build on the direction of travel that has been established in these legislative and policy developments, and to learn from lessons of previous reviews to ensure that these aspirations become a reality within the next 15 years." 11:41

That would have been by 2020 to 2022. In terms of the size of that challenge, just touching on what the Chair

had already alluded to in his question, was there consideration given to a means of accountability checking over that period, you have answered the question already, but was there any consideration or scoping about how, you know, recommendations would be at least checked over, over that foregoing decade and a half, or following decade and a half?

A. I was not involved at the later stages. I ceased to be involved directly from about 2011. Once the group of experts set up by the Minister to see the first phase initiated, really, we were stood down.

But to its credit, the Department set its own kind of monitoring process which is very transparent in its action reports, particularly the early reports. So, I think it was conscious that it needed to make itself transparent and accountable to the public at least.

64 Q. In terms of the Department, I know you are commenting and giving evidence from the Trust perspective, but in terms of your position as an expert and someone familiar with all the issues at hand were periods of action, as you perceived it, more activity, in other words from the Department, driven by other factors or were there ulterior factors or outside factors, external factors, that drove activity or inactivity, as the case may be. I suppose what I'm really driving at is, did periods of direct rule or an Executive bear on activity or inactivity, as the case may be, in terms of taking the recommendations forward?

A. My sense of it all was that the Department was very committed and it tried hard to get a significant bid in the comprehensive spending review. It was dumbed-down initially and we needed to challenge it, there was only a few millions was initially offered, then we got it up to £47 million and our Bamford request was for £54 million, I think, for the first phase. 11:43

65 Q. What precisely was that money for just so the Inquiry understand?

A. That is the total implementation of the first phase of Bamford. 11:44

66 Q. The first phase?

A. The first phase of the Action Plan. I think the Department was competing with other health demands. But they did manage to increase the commitment financially significantly, until the Lehman Brothers crisis peculated through the public sector throughout these islands in 2010, '11, and seriously afterwards. 11:44

67 Q. I suppose to go back to my question, I suppose I was asking whether or not you feel able, and if you don't I understand, but whether you feel able to comment on whether or not devolution or an absence of it has had an impact on the taking forward of the recommendations? 11:44

A. I think it -- the Direct Rule Ministers when we were working with Bamford were actually quite successful. There was, in a sense, ways that they didn't need to have to consult widely with executives and stuff, things happened and we had Sean Woodward for quite a while and that was very successful. 11:45

68 Q. He was a Direct Rule Minister?
A. Direct rule. Yes. Interestingly though, when it came to legislation I was in fear and dread because with the Direct Rule Minister we would be tied to a Westminster view of the legislation which was very much opposed to anything like fusion legislation. And with devolution ending and David Ford becoming the Minister For Health, who in his day had been a student of David Bamford in social work, with a social work background and mindset, he saw, because it was across departmental -- 11:45 11:46
69 Q. And just so the Inquiry is aware, David Ford was the Minister for Justice.
A. Minister for Justice, and of course Minister McGimpsey at the same time.
70 Q. He was the Minister For Health? 11:46
A. Minister for Health. I mean, in the present administration it is clearly a hold-up for getting legislation, hold-up for legislation through. And we have two pieces of legislation on the statute books that I would have been associated with coming through in 2016, still not implemented, one being this "fusion legislation". 11:46
71 Q. Yes. Coming back then to just Equal Lives. Paragraph 33. This is where a layperson like me is at a disadvantage, the Panel Members will be more familiar. But I wanted to give you the opportunity to expand a little bit for the uninitiated in terms of what is meant here by some terms. So, the Equal Lives Report did address different models for learning 11:46

disability care in what was described as a traditional or medical model and the social model. First of all, can you just explain for us what those mean?

A. As best I can. I mean the medical model, of course, is really the idea that you're, you know, you have a patient, me as a patient, whatever, and I have a condition, a diagnosis was made and I need help with that condition and it is treated. It works well for cancer. It worked well for heart disease. 11:47

72 Q. Yes. Physical ailments, in other words? 11:47

A. Yes, it does. But modern medicine recognises that that is a narrow model too. I think modern healthcare and, therefore, modern medical education, for example, needs to be much more holistic and see the person who has responsibility and ownership of their condition. It is a person, not a disease that you're treating. 11:48

73 Q. Yes?

A. As you move across the spectrum to mental health, that becomes much more of an issue looking at the psychological and the social domain. So the medical model in psychiatry has expanded to the biopsychosocial. 11:48

74 Q. Yes?

A. Where you see the social context, peoples' living conditions. We know, for example, how much health is related to equality or inequality no matter what the physical health or mental health. So that is very pertinent in learning disability, where it is not even about disease, it is not even about illness, it is 11:48

about intellectual vulnerability and limitation. So, what you need is a leg-up in life across the spectrum of housing, recreation, use of time, relationships.

75 Q. So, to your knowledge, and when I say to "you", I mean to the Team, to the Team's knowledge, the whole Team's knowledge, was this something that had ever been done before in terms of this underpinning of the Review's work, the employment of this model, biopsychosocial model? 11:49

A. I'm not aware, I think it was a personal vision that they had about inclusivity, kind of a whole person, a whole situation approach. I expect they have been informed by other initiatives elsewhere, and I can't assume that hasn't been the case. But it was a perfectly natural, I mean it was in the air of their whole attitude to the way they wanted to be different from mental health, and not to be too contaminated by a mental health strategy that was dominating the rest of the review. It was a very person-focused approach to normalisation and socialisation. So it was really a concentration, a condensing of that philosophy down to that word "biopsychosocial". 11:49 11:50 11:50

76 Q. You have very helpfully set out in your statement at paragraph 35, and I am not proposing to go through them, but the recommendations, the areas that they covered and then the objectives. In other words, you helpfully married-up the objectives and recommendations. 11:50

But what you then tell us at paragraph 37, if I can just bring that up, is the identification of particular difficulties associated with resettlement and the identification of a significant future problem. But the Review, the Equal Lives Report was very clear in terms of what needed to be done. You have pointed out there Recommendations 27 and 28 of the Review, and Recommendation 27 is by June 2011: 11:51

"All people with a learning disability living in a hospital should be relocated to the community; Funds need to be provided to ensure that an average 80 people will be resettled per annum over the five-year period from 2006 to 2011." 11:51

Then Recommendation 28:

"With immediate effect, all Commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability. Hospitals will not provide this service from 1st January 2008." 11:52

I suppose we can separate them or take them together, whichever you are more comfortable with, but the question I have in relation to each is the same: Were they intended to be indicative for aspirational, or were they intended to be directional? In other words, this has got to be done by these dates and within this 11:52

timeframe?

A. It was a very strong commitment on the part of the Equal Lives Group that that's where they wanted to be and it seemed reasonable. The timeframe slipped for them for the reasons we've already discussed. But if your place shifted, what they're really saying is over a five-year period, when the clock starts ticking, we should have people out of long-stay learning disability hospitals and that was the kind of numbers that you needed to be moving. The costings were built into that notion, that these people would have to be relocated. 11:52 11:53

77 Q. But the recommendations were recommendations to central Government to the Trusts, to the people tasked ultimately through a myriad of responsibilities, tasked with the care of people who were long-stay inpatients in Muckamore and other hospitals. So those are the people you were speaking to, or the Review Group was speaking to. 11:53

Do you know whether anybody came back to say, that is just not going to be do-able within the timeframe, or give practical reasons why not? Do you know whether there was any feedback along those lines? 11:53

A. There was a very positive response from within the system as a whole, I felt. We would have picked up resistance in that first phase. Professor McConkey preferred to be a member of the Ministerial Group, I was Chairing that group with him and he was keeping a very close watch on the implementation side for 11:54

learning disabilities so I could concentrate on mental health. But he was, I think with me, very positive about how things were going in the first phase.

78 Q. Taking Recommendation 20, for example, because it is, the urgency of it is self-evident: 11:54

"With immediate effect, all Commissioners should ensure they have resourced and implemented arrangements."

He even talks in terms of emergency support and accommodation. That's not the sort of recommendation that one puts forward, you know, in the ether. That is a recommendation that is put forward by a group in the expectation that something will be done, would that be fair to say, and done quickly, hence a date? 11:54 11:55

A. Yes. Yes. It's a model that moves away from hospital provision for people with a learning disability, but recognise that in the limit some individuals at certain points may be in a crisis situation, maybe a mental health need, and you need some form of provision other than hospital. I think there's discussion to be had around that model, even today, but that was their view and we respected it and supported it. 11:55

CHAIRMAN: Again, can I just ask: How does this square, these recommendations, how do they square with the evidence that you gave earlier that you recognise that it wasn't until the last of the reports was in that you were going to make, a sensible bid was going to be able to be made and the Department would be able 11:55

to look at it as a whole to decide what the funding was going to be?

Because this talks, for instance, about "80 people will be resettled per annum over a five-year period from 2006", well that's a year before the last report comes in. So how was that actually going to work or am I just misunderstanding? 11:56

A. 2011, '12 I think it would imply that it would be completed. Five years from 2006. 11:56

CHAIRMAN: But was it understood that in fact, at the time these recommendations were made, you were actually going to have to wait until the last report was in before the wheels would start moving?

A. Clearly, no. 11:56

CHAIRMAN: Okay, that is what I wanted.

A. They thought that they could activate that as it is written.

CHAIRMAN: Well quite, because on the last line of Recommendation 28 is "hospitals will not provide this service from 1st January 2008." That would have been very aspirational, wouldn't it, given that the last report came in in 2007? 11:57

A. Yes.

79 Q. MR. McEVOY BL: Presumably, and I know the extent to which maybe you can comment on the thinking behind each of these recommendation, perhaps limited because of your relative authorship or absence of it, but presumably then, notwithstanding what you told the 11:57

Inquiry earlier on about getting everything together before it went forward, getting all the reports in situ. There must have been an appreciation that, notwithstanding all of that, there were still urgent steps that needed to be taken? 11:57

A. Absolutely. I mean, by taking a "let's go through it together" approach, which was the approach the Department adopted, all jump together, and starting in 2008, this whole thing, the only phase shifted two years. Considering what was at stake, and the 11:58 arguments I have given for the benefits of taking it through together, particularly in relation to infrastructure, I think the model of moving that over a five-year period, if the money had kept coming, was reasonable. 11:58

80 Q. I'm not sure if you can help us with this. Just towards the end of paragraph 39, there is just a mention of a system of priority ratings which is part of the Equal Lives Review. It starts, the internal paragraph number is 1250. 11:58

A. Oh, yes.

81 Q. Can you help us with how those were formulated and how the priorities were assessed, just as a sort of mechanism? If you cannot, we understand?

A. I wasn't personally part of the detail of this, but 11:59 I can understand what it means, I think. In that, pre-implementation support was a need to gather the relevant forces together to make this happen. Cross-departmental support, for example, would be a

particular issue. And then a plan.

So you weren't wandering aimlessly. You were trying to take something through a very big change. This was quite a big change in the culture. Obviously pump priming, immediately resourcing to make that happen. Then medium term resourcing was really to see the bulk of the whole process being implemented. 11:59

82 Q. Just picking up on what we have discussed about the getting together of all of the reports into one final package so that you could go and put it forward for funding, or those responsible could take it forward for the necessary funding. There's a delineation there at (iii) and (iv) between immediate resourcing from 2006 to 12 and then at (iv) for medium term resourcing from 2012 to 2020. 12:00 12:00

A. Yes.

83 Q. Immediate resourcing would have been for a period prior to presumably then all of the reports being finalised, is that right? 12:00

A. Of course. Because this report is written with the mindset that we can start once we publish this report. Everything is time-locked to that view, 2006 being the start date.

84 Q. Is that (iii), is that the pump priming you refer to or is that something else? 12:01

A. It's really expecting things to start up once the report has been received. And it's published in 2005, you imagine things will get going into 2006.

85 Q. So there should be money on-stream immediately?
A. Yes. But of course for the arguments we've heard, we've talked to these things, actually moved back two years. The startup is 2008, 08/09, being the first year of the Action Plan. 12:01
86 Q. Okay. So, the next part of your statement deals with the conclusion to the Equal Lives report. I suppose picking up, in particular, paragraph 40. There's the internal, which is at the top of the next page, 17, the internal paragraph 12.58: 12:02

"The enthusiasm and dedication that has been evident from the many hundreds of people who have participated in the Equal Lives Review demonstrates that there is a strong commitment to improve the quality of lives with 12:02 people with a learning disability and their families. The challenge now will be to ensure that the aspirations contained of in this review translated into action across Northern Ireland in a way that ensure that people with a learning disability really can 12:02 experience equal lives in the future."

Paragraph 42 then, just the bottom of the page, you make reference to the May 2000 strategic priorities for the first phase of Review implementation. Going 12:02 overleaf:

"It was envisaged that when the Equal Lives Report was give to the Minister in September 2025, implementation

would commence in 2006. The May 2007 document reflected on internal page 105 that there was already delay."

You then comment at the very end of that section, Professor: 12:03

"Sadly, the vision outlined in the Equal Lives Review has not been realised and the detailed roadmap that it devised towards the vision was not followed. The investment needed to make it a reality was not provided." 12:03

Setting aside the question of investment, for reasons that you mentioned, austerity may be my word, not yours, but the years of restriction on the public spending and so on, are there any other factors apart from those extrinsic financial pressures outside Northern Ireland that impeded the progress along that roadmap? 12:03 12:04

A. I do believe so. I believe one very important factor is that the issue of a work strategy, workforce strategy, needs to be brought into the centre stage as to how that was going to impact on bringing through a lot of the change that was the necessary, particularly in the health and social care sector. 12:04

We considered it crucial for the success of Bamford that there was a workforce strategy. We also

considered it a priority. And that was reflected in the Strategic Priorities Report, which, if you would like, I can refer you to.

87 Q. Yes, by all means. Do you have the reference?

A. Yes, indeed. If you turn to page 24 and 25. 12:04

88 Q. Which year is that report?

A. It's the Strategic Priorities Report.

89 Q. That's the 2017 one for the first phase?

A. Sorry, no, it's the Reform and Modernisation of Mental Health Service in Northern Ireland. It's the Bamford 12:05 Review final report that I added to all the reports. We have been using it, we have been referring to it already.

90 Q. Its 1500.

A. Thank you. 12:05

CHAIRMAN: It starts at 1477, doesn't it? Oh, I see.

MR. McEVOY BL: Is that the page we were looking at?

A. That's correct, thank you.

91 Q. That's the one.

A. 1500, thank you very much, yes. Can I refer you to 12:06 workforce and training just in the lower part of that page. If I can just note with you the following, this is what we state in 2007:

"The Reform and Modernisation of Mental Health and 12:06 Learning Disability Services hinges on a sufficient and competent workforce. The provision of Modern Mental Health and Learning Disability Services can only be achieved if we have a workforce which is able to

develop new ways of working which build on best practice and challenge some of the traditional ways of doing things. All areas of the Review anticipate changes in workforce practice, an increase in the numbers of staff, including the imaginative and creative involvement of support staff, volunteers, users and carers."

Then just the next sentence: 12:07

"The early establishment of a comprehensive workforce strategy or strategies for both Mental Health and Learning Disability Services is an urgent priority."

Could I just take you over the page to the next paragraph? 12:07

92 Q. Of course.

A. Where it says, and here I would like you to think Muckamore Abbey Hospital:

"At local provider level, the changes and the process of change will present formidable challenges for all staff. These challenges must be adequately prepared for. Robust service organisation, team-working and communication will be pivotal in realising and maintaining the reforms. 12:07 12:08

These must be complemented with a comprehensive workforce strategy embracing recruitment, retention,

training, supervision and the participation of users and services. The Review, in consultation with the Department, has prepared a separate workforce framework."

93 Q. I wonder should we look at that now, that Framework? That is, hopefully, 1596? 12:08

A. It is 6117 in my document.

94 Q. It should be 1596?

A. But before we go to it, it is important to note that this was prepared in consultation with the Department, it wasn't just us throwing something at them out of the blue. 12:08

95 Q. The Framework?

A. This Workforce Framework, yes, that we're now turning to. 12:08

DR. MAXWELL: I think it starts on 93. If you go back to 93.

96 Q. MR. McEVOY BL: The introduction, then, is at 93. Can you tell us, it might be helpful for the Inquiry to know whether it was ever actually developed, what was done with it? 12:09

A. To the best of my knowledge there's been no Workforce Strategy by the Department to date of any kind. I can't find any. Certainly in my time there was none.

DR. MAXWELL: Can I just ask a supplementary? So I know that in Northern Ireland there have been a lot of Service Frameworks with associated Workforce Plans. 12:09

I know at some point in your evidence there was a

discussion about a Service Framework for people with learning disabilities. Has that Framework been completed and would that have a Workforce Strategy associated with it?

A. If it were completed it ought to have a Workforce Strategy, but I'm not aware of its existence, but that's my ignorance. 12:10

DR. MAXWELL: That is maybe something we need to follow-up because there is certainly no other Frameworks here in Northern Ireland that have Workforce Strategies associated with them. 12:10

MR. McEVOY BL: As far as you are concerned, what is proposed in Annex 8, nothing has been done to activate that meaningfully.

A. But in relation to the Inquiry's current concerns, the absence of a Workforce Strategy around those issues I have been mentioning, communication, preparation, change of role. This was a resettlement not just for patients, this was a resettlement for staff. I don't think that was ever realised. 12:10

97 Q. Yes. Can you tell us a bit more what you mean by that in practical terms?

A. Well I think the Inquiry's own report of 2020 speaks volumes where you have staff anxieties not knowing where the future is and where there's high levels of sick-leave, absence, and a large amount of agency working which is not the stuff that is conducive to improved quality of patient care. 12:11

I can't say there is a one-for-one relationship because of the absence of a Workforce Strategy, but the Workforce Strategy ought to have had as one of its central concerns the impact of change on existing staff and their roles. This is across the piece, including mental health. We have massive work to change at changing the way nurses see their roles, as opposed to just caretakers in mental health. Their therapeutic role and their training and skilling. They are the lifeblood of our Health Services, the nursing force. 12:11 12:12

98 Q. After your discussion in your statement of the Equal Lives Review, you provide a section dealing with subsequent developments. At 44, just following on from what you mentioned about the roadmap not being followed, you say that you do not mean that nothing was done. Steps were taken, some money was invested, but not enough of either to see the necessary changes brought into being. This is back at page 18, please. Thank you. 12:12 12:12

Then you reference the June 2008 consultation documented delivering the Bamford vision. That begins at page 3100. Sorry, if we can just jump forward to that. Now, within it there's a foreword from the then Minister, Minister Poots. This is page 13, I beg your pardon, 3101. There's a foreword. Have you got that in front of you, have you got the -- 12:13

A. Yes, I have it in front of me.

99 Q. I'm going to ask for it to be brought up on screens.

It should be page 3101. The second page in fact, sorry, 3102, I beg your pardon, the Minister says in a paragraph which begins:

"The Bamford vision set out a 10-15-year timescale for the enhancement of mental health and well-being, and for learning disability services. A strong foundation has been established and a positive change is evident, but we still have much to do in order to deliver that vision." 12:14

When he talks about a "strong foundation" as at the date of this report in 2008, was he right to say that? Could he say that with confidence?

A. I expect that he's alluding to Government commitment and the finances have been identified and the Executive has signed up to the whole process and the good work of the Bamford Review has given us the vision and so forth. You need that behind any drive to change. It's not, it's more ethereal than substance, if you know what I mean? Nothing has happened. There's no actual physical foundation. 12:15

100 Q. No detail?

A. The impetus is in the air.

CHAIRMAN: So a positive change is evident. He is talking about political will as opposed to anything real. 12:15

A. Yes.

MR. McEVOY BL: There's then, you mentioned going back

to your statement, paragraph 46, after that consultation exercise, delivering the Bamford vision exercise in October 2009. There's then an Action Plan. Paragraph 50. If you can just move forward to paragraph 50, Section 3.4 of the Action Plan dealt with "Investment in Services". If I can just read out from the extract that you have included:

"People with a mental health need or a learning disability benefit from services funded by a range of Departments, but DHSSPS, DE...". 12:16

Which is the Department of Education, is that right?

A. Yes.

101 Q. "...and the Department of Social Development are key contributors. DHSSPS and DE have specific funding streams devoted to services for these groups of people. Within DHSSPS' area of responsibility, just over £200 million was spent in 2007/2008 on Mental Health Services and just under £200 million on Learning Disability Services. It is estimated that around £200 million was spent on services for older people with dementia, and together, accounting for approximately £6 million, or almost one-quarter of the Health and Social Care Trust's expenditure. However, too high a proportion of mental health and learning disability funding is spent on hospital services. The aim is to provide more care in community settings." 12:16 12:17 12:17

That was clearly something that was, I mean this is a departmental paper as I understand it, it was clearly something that was in their minds. Did they come and say to you, we need more help from you. We need your input in terms of how we go about reducing this in a proportionate way which is consistent with the vision that you have set out?

A. Yes.

102 Q. They did?

A. Yes. 12:18

103 Q. Can you tell us more about that?

A. Just repeat your statement?

104 Q. I mean there was clearly a cognizance as this Action Plan indicates, there's a concern, I mean the Department is setting it out very clearly, a recognition that there's a proportion of mental health and learning disability funding spent on hospital services is too high --

A. Yes. I just wanted to make sure I got your question.

105 Q. To come here and say, you have got to help us with this. You guys have been looking at this since 2002. Can you help us? Was a message like that or in your terms communicated to you or a request?

A. It's one view of the world and it is an important one. It feeds into the more broad-based vision of change and reform modernisation. But part of that is the view, I agree with the view that the proportion, the amount of resourcing spent at keeping people and supporting people in hospital is out of kilter. And it is a

significant part dominated by the people in longer term support in hospitals that ought not to be in hospitals, but could be better managed in community settings.

That can release money, and the notion is, if you can release the money you can actually build a community. That is true, but it's only true to a part because the hotel costs in long-stay situations are typically less than most community situations. But secondly, you're not just after hotel costs, you're looking at the quality of peoples' lives and that's other issues like access to services, access to help, and education, and so forth. 12:19 12:19

106 Q. Did you go, and when I say "you", obviously I'm talking corporately about the Review Team, go back, having obviously, I presume, looked at the Action Plan, absorbed it, even if the Department didn't come to you before writing that, or after even writing that. Did you say, look, we know what you say here, Section 3.4 about the proportion or the too higher proportion of expenditure in hospital services for people with mental health and learning disability needs, but you have got to understand, you know, people in that situation can't be left high and dry. You've got to make sure that provision is made for them. Do you know whether that message was translated? 12:20 12:20 12:20

A. Are you referring to the people who are still in hospital?

107 Q. Yes?

A. Yes. No, we didn't. We were geared to the view that people who are in long-stay hospitals, mental hospitals, or learning disability hospitals, should be in their community. So the process was, get them out, find a way, find solutions. It wasn't in our writing of Bamford, or in our early implementation thinking, what about the people who are left behind? That is why I say I put my hand up as part of this. We might have thought about the process and the impact of the process of change on staff and the process; we certainly had a work strategy in our mind for staff, but while that was happening perhaps we should have given more thought to the patients in the process change, that two to five years or whatever. 12:21 12:21

108 Q. Because at this point in time in the context of this Action Plan, you know, the Department is communicating that sentiment very clearly. 12:21

DR. MAXWELL: Can I just ask a question on this: On page 3018, there is a review of the spending in 2010/'11 because there had been a target that 80% of the LD spend should be on community services, by 2010 82% was on. This statement is quite vague "too high a proportion." In your report you were recommending that 80% was spent in the community, but by 2010 that target had been exceeded. 12:22 12:22

MR. McEVOY BL: 3018?

DR. MAXWELL: Yes, well according to my notes if I have measured it properly.

CHAIRMAN: Paragraph 5.7.4, I think, at the bottom of

the page.

DR. MAXWELL: Yes. So was the problem the proportion or the total quantum of money available for LD?

A. In relation to what?

109 Q. DR. MAXWELL: Well, if there wasn't enough community provision, was it actually because too much was being spent in the hospital, or was it that the total amount on LD in total wasn't enough? 12:23

A. I think the latter is the dominant factor here, but we're just getting going by 2011. It's in the right direction. 12:23

110 Q. DR. MAXWELL: So the proportions might be right but the total amount of money meant that neither the Hospital nor the community had enough.

A. Yes. 12:23

111 Q. DR. MAXWELL: But it wasn't the division between them that was wrong?

A. No. I think more money would have tipped the whole thing in the other direction. I think there is the myth around that if you just move people to the community, you release their money and that will do it. And apart from bridging finance methods, which is extremely important to get you through that, you still find when you're looking after people with complex needs in the community, it is an expensive model. And that's what we were building our funding basis or bidding basis, our financial costs on, the assumption that this is more expensive than a hospital-based warehousing kind of model. 12:23 12:24

CHAIRMAN: Do you factor, it's a terribly complicated calculation, I imagine, because if you just look at it in one year it will be undoubtedly far more expensive I imagine. But the long-term saving of closing an entire hospital and selling the estate, does that get factored in or not? 12:24

A. I know people back at Treasury are considerably exercised by the possibilities of the estate value. I think Roy McConkey gave good examples.

CHAIRMAN: He mentioned it, yes. 12:24

A. And his experience in Scotland where that was used by, which Trust?

CHAIRMAN: I can't remember either, but I remember his example.

A. They had a big spend as a result from it. But I think the situation in relation to Muckamore wouldn't have necessarily been a big money source given its rule. 12:25

CHAIRMAN: Also, I suppose somehow you have to factor in the potential long-term benefit to the patients who may be getting better care. 12:25

A. To me that was the only issue. It is not about whether it costs more or less, it is about what's right. There will be a release of money eventually. The estimate was, I think, it was £20,000 per patient per bed in Muckamore. So, you know, when we talked about £80,000 per year for a community placement, it wasn't nothing in hospital, it is quite expensive. So you do release money. 12:25

DR. MAXWELL: Can I ask you, obviously some of these

problems have been experienced by the rest of the UK, so closure of major hospitals in England, for example, took place in the '80s. Did you seek out information from England about some of these problems?

12:26

Because for me, some of what you are talking about is very, very familiar. So, for example, being left with a lot of very challenging people as you start resettlement, that was extremely common. I think it probably happened everywhere a big hospital was closed. 12:26
Likewise, some of the costing issues have been very well thought through over there, simply because they were doing it 20, 30 years earlier.

A. I'm not aware because I wasn't involved in the financial resourcing or management of any of this. 12:27
We certainly consulted on models of care widely and sought insight from colleagues. For example, I had my opposite number in relation to the Service Framework for Mental Health who I met up with. We were also encouraging and did visit other centres outside of the 12:27
UK. I think Roy McConkey mentioned Sweden. I visited Sweden to look at their community care model for mental health. But at that stage we weren't looking at the cost aspect of the model, but we were fairly sure it was going to cost us more, inevitably. I have to say 12:27
the learning disability problem has not gone away in England either, I mean it is still there, there are still resettlement issues.

DR. MAXWELL: Yes, but its much, much, much smaller

than here per head.

A. Today ours is quite...

MR. McEVOY BL: While we're on the Action Plan, are you okay to continue? Could you use a comfort break, please say. 12:28

A. No, that's all right. I'm doing fine. Thank you.

112 Q. If we could move down. It is the same exhibit or it should be, 3124, there's a paragraph 6.6, Professor, "Resettlement":

12:29

"There are currently around 200 long-stay patients in learning disability hospitals who no longer require hospital treatment and who could be resettled into the community. As with mental health, work will continue over the period of this Action Plan to seek alternative 12:29 care arrangements for as many of these people as possible with the current funding of...".

And this is the figure I think you mentioned this morning of 6.4 million:

12:29

"...identified for this and to identify options to achieve the long-term objective to complete the resettlement programme by 2015. The principle of betterment will continue to inform decisions."

12:29

Can you tell the Inquiry what you understand by the "principle of betterment"?

A. I understand that is about quality of life and what the needs are of people to have Equal Lives, what underpins

that concept of an equal life and improvement in their life situation compared with being in a hospital situation.

113 Q. So, in other words, if they are leaving the Hospital to go into the community, things should be getting better for them, life should be getting, their quality of life should be getting better? 12:30

A. Yes, it's not just a matter of putting patients, as it were, in a box somewhere else.

114 Q. Yes, moving the problem out of the hospital to somewhere else? 12:30

A. Moving the problem. It is what does equal life mean? What does that cost per year, per person, that person. And if that cost £120,000 per year for that person to give him something like, or she, something like you and I have, then that's betterment, that's what it's for. 12:30

115 Q. In your view, and with the benefit of your experience, did the principle of betterment continue to inform decisions after this Action Plan?

A. Well I think there was resettlement continuing, so they obviously did achieve that. I refer to the Northern Ireland Housing Executive Report which makes quite good reading. It does seem to suggest that quite a lot of relocation in domestic kind of situations was being achieved. 12:31 12:31

And my discussion with Joe McGuinness, who is a consultant, had been a Clinical Director in Learning Disability Services in the Southern Trust, described

the kind of changes and the kind of improvement that were achieved in subsequent years. So I think a lot has been done, but we are still down to a core of people that have not yet been relocated.

DR. MAXWELL: Do you have any idea what the challenges around resettling that core who are left are? 12:31

A. Yes, I have thought about this. It seems that the Trust's approach to much of the resettlement programme is depending on the private sector and its a private sector solution they're finding all the time. If the private sector can't come up, they're stuck. 12:32

So I think there is a problem in either getting the private sector to come forward or else for the Department to step up and say, look, we need across the Departments to be finding a solution here to our learning disability community, not to hang behind a devolved problem to Trusts who have not got the resources to provide a domestic model themselves. 12:32

DR. MAXWELL: And cannot purchase it. 12:33

A. They can't purchase it.

DR. MAXWELL: Could I ask about this core set of people that you're describing. Are you referring to everybody in Muckamore when you talk about that? Because we are aware that there were assessment and treatment beds and you say at the beginning of your report that you expected that Muckamore patients would be resettled into the community, apart from a small assessment and treatment unit. 12:33

A. Yes.

116 Q. But certainly in the RQIA 2016 report there were 87 people described as being in the assessment and treatment beds. Now, that doesn't sound to me like it's small and it sounded to me like; were these the new long-stay Muckamore patients? So could you clarify when you are talking about the core that needs to be resettled, are you just referring to the resettlement beds there, or are you referring also to the assessment and treatment beds? 12:33 12:34

A. Well, insofar as the situation that you described pertains regarding assessment and treatment, the numbers, I agree with you, sound large. I think if you come back to the ideals of the Equal Lives group, much of the assessment and treatment ought to be provided within a community setting. 12:34

DR. MAXWELL: Absolutely.

A. Small units are quite capable of doing this.

DR. MAXWELL: Absolutely.

A. But there are perhaps; I think this is a matter of debate and I think it is not local, it's an international issue. Do you need sometimes some beds in a hospital, healthcare staffed situation or not, or can you do it in a community facility that basically has the skills to do whatever needs to be done to help individuals to get through their crisis, treat their mental illness. 12:34 12:35

We do know, for example, in South Stockholm, they have

done that for mental illness. I've seen that. We haven't achieved that and the model that we have bought into, and it is fairly universal around the UK, it is about 40 beds per 100,000 for mental health, and it seems to work. If you go to a different model, I think you probably need a much greater invested system than we have with small community homes.

DR. MAXWELL: Yes, but the crucial question is: How many assessment and treatment beds would you need for learning disabilities per-hundred-thousand? And the number, if it's anything like 87, as it was in 2016, that is a very large number compared to other areas I have worked in.

A. Yes, absolutely, I would agree with you. My understanding, for example, in the Southern Trust, it's a 10-bed assessment unit. That was achieved, serendipity is often very important, it is part of the Southern Board's strategy during this difficult period, there was a plan for mental health to have a second Alcoholism Unit there and they decided not to go ahead with it.

Again the Clinical Director, Joe McGuinness took the initiative and asked the Department if he could have the assessment unit beds, beds for an assessment unit, she will commit to relocating the long-stay patients, getting the extra resources released by that mechanism. And they use I think a 10-bed assessment unit for a population of 250,000.

DR. MAXWELL: Yes, that's more the sort of size I would expect.

A. So you're talking probably about a 30-bed assessment unit.

DR. MAXWELL: At the very most, I would say. 12:37

A. Muckamore is covering three-fifths of the Province at the minute. It cover three Trust areas, northern Trust, Southeastern and the Eastern. It also, I think has still got a forensic component to it for the region. So it had always been seen as a sort of 12:37 Regional Unit for difficult issues tend to move towards. That needs to be factored in, but I'm not an expert on the details, but I agree with your direction of travel here.

DR. MAXWELL: I suppose the real question is: Were the 12:37 community services improving sufficiently? Did they have sufficient multi-disciplinary intensive support teams to support people out in the community to stop them having to go in to assessment and treatment beds and create a new long-stay population? That's the 12:37 crucial question I think.

A. It is, and from my impression on the ground, that is what they are trying to do. Patients are no longer admitted, insofar as possible, that they are managed in the community. So there's a very strong commitment to 12:38 that end of the problem. I do think it probably needs more investment these days, just given the history of the problem that we've looked at and it hasn't got better.

There's a new Mental Health Strategy, by the way, and I think this Committee ought to take note of it because there is scant mention of the mental health needs of people with a learning disability. That is a 21 to 31 strategy, ten-year strategy. It would deal with those kinds of issues. It ought to be prioritised. 12:38

There are specialist areas in mental health and there's a mental health of learning disability. I don't think we should throw the baby out with the bath water here. There is a core need, mental health need, and it needs specialist skills and specialist staff wherever they are based. 12:38

MR. McEVOY BL: Professor, at paragraph 55 of your statement then you make reference to the November 2012 Mental Health Action Plan published by DHSSPS. This is the Action Plan for 2012/2015. You quote from it then quite extensively in the following paragraphs. 12:39

A query arises in relation to internal, the paragraph is 57, the statement paragraph is 57 and then it is the internal paragraph 1.9 within that. So it should be page 24. So reference is made there to: 12:39

"Transforming Your Care (TYC) 12:40

A Review of Health and Social Care in Northern Ireland which was published in December 2011 has many parallels with the Bamford vision in respect of mental health and

learning disability provision and enhancements."

Then it goes on to list a series of items. Can I ask whether you can tell us about the crossover, the extent of the crossover between transforming your care and Bamford? 12:40

A. That's a good question. I am not competent to answer. Because at this stage I am disengaged focusing on legislation at this point. But it did seem that there was an attempt to measure the ideals between the two processes. 12:40

117 Q. Do you know then, maybe you are not competent to answer the follow-up, but do you know whether there has been any evaluation of "TYC" on people with learning disabilities? 12:41

A. I don't know is the answer.

118 Q. Okay, and you don't know presumably then about the status of TYC currently in guiding the Trust's planning of services for people with learning disability?

A. Your statement is correct, yes. 12:41

119 Q. Now, paragraph 59 then. This is, I think, looking at the same Action Plan. Your introductory sentence at paragraph 59 is:

"It is of significance importance to understanding the key problem, is what is set out at paragraph 3.13." 12:41

That is of the Action Plan and then you quote from it:

"Funding will continue to be a significant challenge in the period 2015 and beyond. There is continuing pressure to achieve efficiencies. The only additional funding to the health and social care sector earmarked for mental health and learning disabilities services over the budget period 2011 to 2015 is £9.2 million."

CHAIRMAN: You need to slow down a bit.

MR. McEVOY BL: Sorry:

"The only additional funding to the health and social care sector earmarked for mental health and learning disability services over the budget period 2011 to 2015 is £9.2 million, £2.8 million for mental health, and £6.4 million for learning disability, to continue the resettlement programme." 12:42

What is the key problem, just in a sentence? What is the key problem?

A. Public sector funding crisis. 12:42

120 Q. Now, we mentioned the figure of £6.4 million a number of times this morning.

A. Yes, indeed.

121 Q. So we're absolutely clear, what would have been required, what kind of figure would have been required to resettle all the patients? 12:42

A. I think the figures are already in the details that we've given.

122 Q. Is that the 173?

A. Yes.

123 Q. That's the gap, that's the £173 million that we looked at this morning?

A. The proportion of that.

124 Q. The proportion of that relative? 12:43

A. Spread across the cycles of action plans should achieve that. And the achievement got during the first phase is a measure of what can be done if you have got the money. So it is a big factor in making things happen.

125 Q. At paragraph 60 then you say that: 12:43

"The only additional funding that was to be made available for learning disability in the 2012 to 2015 period was £6.4 million. The contrast with the 2009 to 2011 Action Plan, which itself did not provide the 12:43 amount of funding, that we had identified as necessary, will hopefully be obvious."

So there's a pattern, or certainly a trend of insufficient funding getting smaller, were you alerting 12:44 the Department to this and to the impact it was likely to have?

A. I think I'm out of the system at this point because this is 2012. I'm no longer on the Ministerial Group. It had been stood down. I think it lasted 12:44 two-and-a-half years to get the first phase up and running.

So I was aware of this and I was in conversation with

them at this time and I was on the mental health side, where it was even more disastrous. We were looking at things we could do in relation to cultural change that wouldn't cost money and that's where the Recovery Colleges Initiative started from which I think has been extremely successful, but I mean they were strapped. 12:44

126 Q. I appreciate there is a public sector funding crisis, but I mean having been so close to the work of the Equal Lives Review, given your Chairmanship of the Bamford work, did you feel that it was within your gift or your compass to go back to, or to go to the Department and say, you know, we did years of work here, lots of it, and it is at risk if this funding continues in this trajectory? 12:45

A. I think our collective disappointment was palpable, you know. I think the Department was very disappointed in what it had been landed with. My main frustration when I left the Review was the absence of a Workforce Strategy because, you know, you can do a lot without a lot of money if you have a Workforce Learning Programme going. 12:45 12:46

127 Q. Would work on the Workforce Strategy, and I don't want to overstate this and if I am wrong you will correct me, but would it have at least helped to mitigate some of the effects of the public sector spending squeeze? 12:46

A. If it had been up and running when we said it was immediately required it would have got a lot of the skill base up and a lot of the cultural change within staffing set. It would have run into a funding crisis

as well, but I think in proportion to the budget, a much smaller budget. That's why I say the Recovery College, which is really a cultural change, you can do a lot with a few staff and training.

CHAIRMAN: I mean the cultural change, does that come about by training or issuing protocols, or how does it actually manifest itself? 12:46

A. I think you need; there are several strands to this. It deserves more time than me speaking off the top of my head. But, you know, it's leadership. You know, it's about leading from the front. It's about showing staff how things are done by giving them the training, by giving them the supervision and helping to feel supported and not isolated. 12:47

12:47

It can transform people if you hang-in with them and you recognise people in a long-stay caring situation that, you know, you are important, you're not forgotten. And people like me, who are in a leadership role, our visibility in that made a difference and I think they needed champions like that to be in the system. 12:47

CHAIRMAN: It doesn't necessarily need to be expensive to do that.

A. That's exactly right. You need a few people, trainers and supervisors and you can cascade a lot of this stuff as well, you can now use remote learning, of course, you don't have to get people into a hospital seminar room to do this. So it is relatively easy. 12:47

MR. McEVOY BL: Moving forward slightly in time to November 2013. This is paragraph 62 then of your statement. There is a publication then by the Department of DHSSPS of a 33-page monitoring report which is: 12:48

"Delivering the Bamford vision. The response of the Northern Ireland Executive to the Bamford Review of Mental Health and Learning Disability Action Plan, 2012 to 2015." 12:49

You have included that within the exhibits.

Without going into the fine detail of that report, just so the Inquiry understands what the status of that monitoring report was, I appreciate, I think you stepped out at this stage, have you, at November '13? 12:49

A. Yes. I'm out of it as such, but I'm aware of the report.

128 Q. It is because you have included it, that is why I was going to ask you. What was the implication then of the monitoring report for the earlier action report? Did that mean it was relegated or what was the impact of it on the earlier plan? 12:49

A. Well, it obviously recognised what had been achieved to date and then it set out an Action Plan for what was possible with the limited resources. As you know, following this, they set up a series of factors to monitor red, orange, green. 12:49

129 Q. You discussed that then, the sort of traffic light system which measures benchmarks?

A. Yes, their shopping list of what they could do was obviously very limited, but they are making the best of what it is to sell it back to us, you know, this is what we've achieved. But there's only so much they can do now. 12:50

130 Q. What did you feel about that, having seen the comparative lack of progress?

A. Oh, well, I mean it's sad. It's so sad. They seem to have run out of steam writing these reports. It must have been very difficult. 12:50

131 Q. There is then a section in your statement where you talk about your involvement with the Mental Capacity Act and you've touched on it already. At paragraph 71 then, you tell us that you did continue to be involved with Departmental work arising from the Bamford Review: 12:50

"Latterly this related to work to bring forward the Mental Capacity Act which was the outworking of our 2017 report." 12:51

I am trying to slow down as much as possible now:

"A comprehensive legislative framework that was referred to earlier in the statement." 12:51

Then you describe your involvement in summary form, but you have included then in the exhibits a lecture that

you provided at Edinburgh Napier University. I think it is possibly the concept that you touched on this morning, which was that of, now you'll remind me, substitution?

A. Substitute decision-making. 12:51

132 Q. Substitute decision-making. I think it is discussed, in fact, it is possibly the very last page. It should be 3341. I'm just going to give you an opportunity to tell us a bit more about it given that you have mentioned it at the outset. It may be the very last 12:52 page of the entire production. It's possibly in fact 3341. It is actually the penultimate page. There you are, accurate as ever. "UNCRPD Compliance". Is that not a heading, Professor?

A. Yes, that's it there. 12:52

133 Q. And it may be that you want to tell us a bit more about that for the Inquiry's understanding and given what Mr. Ruck Keene had to tell the Inquiry last week about the UNCRPD, and then Professor McConkey, in terms of how all of this fell into the eventual passing of the 12:52 Mental Capacity Act?

A. Alex Ruck Keene, we collaborate closely actually and he is helping us at the moment to look at the under 16s legislation. But he had flagged the problem of the new thinking coming through with UNCRPD and mentions, quite 12:53 rightly, that we made little mention in the Bamford Review legislative document about UNCRPD. We mention it once. It is mentioned in the other reports.

UNCRPD came in in 2006. It was really quite near the end of Bamford and it wasn't actually adopted by England or UK, I should say, until 2009. But of particular relevance, it wasn't until 2014, which is relative recently, that the general, the Committee of the UNCRPD gave an interpretation of UNCRPD, which not everybody agrees with at all. It is really what I'm quoting here as saying: 12:53

"Compliance with Article 12 requires that State parties abolish all substitute decision-making regimes." 12:54

Now, that happened to us while our Bill was at a very advanced stage in the Assembly. It was just ready for consultation. So while this applied to all of the jurisdictions, and obviously much further afield, we were particularly vulnerable. The whole Bill could disappear. Help for us came from several quarters, one particular one was the Essex Autonomy Project. It set itself up to look at whether or not the English Capacity Act was compatible to the UNCRPD. 12:54 12:54

There was a number of recommendations: One was, of course, that the Mental Capacity Act England and Wales 2005 did not fully comply. But the second thing is, they did not think that the interpretation of the UNCRPD by the Committee was correct and we relied quite heavily on that. 12:55

The second thing is, the Essex Project reported again on the different jurisdictions and they referred to the Northern Ireland Act. It's in the report. I haven't got it in front of me, but as I recall it, they describe our Act as innovative. There was some very creative writing and drafting done by our legal team. And the two main factors that they did was to decouple diagnostic disease from impairment and lack of capacity. And, secondly, was the special regard as the Essex Autonomy Project referred to, that is special regard for a person's will and preferences. 12:55 12:56

So our Act goes really far to put the requirement to have a person's wishes in the decision frame. So it felt that we would be as near compliant as you could be and had benefited from the rest of the UK. 12:56

CHAIRMAN: This is my ignorance entirely, and I am sure my panelists know the answer to this, but I do not quite understand how you can abolish all substitute decision-making regime if you have somebody in a severe mental health crisis, for instance. What does it actually mean in these circumstances? 12:56

A. On a personal level, I think it's a nonsense.

CHAIRMAN: It is not such a stupid question then as I thought it was. 12:57

A. I think it is a nonsense. As I said, I think quite early on in my presentation, you must think of the Capacity Act that we have as a fusion act. The arguments in favour of supporting the Act stands

whether it was just a pure Capacity Act, but we're not a pure Capacity Act, we're a combined Mental Health Act with a mental capacity provision, typical provision.

As I said earlier, there is no country that I know of that doesn't have a Mental Health Act running alongside. Ours is fused. I think, as you're intimating, there's no situation where a Mental Health Act could operate without substitute decision-making. We're talking about people who are psychotic. I mean, you just need a few examples, there may be overuse of the provisions, but in the extreme, in the limit you have a person who has no insight and he wants to jump off a bridge because he feels the angels have dammed him to hell or some such delusional thinking. 12:57 12:57 12:58

CHAIRMAN: I think we've got the point.

A. Typically harm to self, but there is also harm to others.

134 Q. MR. McEVOY BL: Essentially what you are advocating for and what the passage of the Act really produced was, and why it has been described as "ground-breaking" is, we are moving away from a model where substitute decision-making is the default for all circumstances. We are moving towards a situation were optimally and where it is possible, there should be supported decision-making but there may be circumstances in which there is no alternative but for substitute decision-making. Is that a fair summation? 12:58 12:58

A. That's absolutely the case and our aim was to put the

criteria around which you would interfere with a person's decision-making, and that should be impaired decision-making capacity.

135 Q. That is what's novel essentially about the Act?

A. What we have done is tackled substitute decision-making head-on and say, look, you do need it, but on the right ethical footing. This is anti-discrimination. This brings the mental health isolated community on a separate Act out of a discriminated single Act situation, and brings them into the same situation for all health and all welfare. In the limit there is a situation where you will need substitute decision-making. 12:59 12:59

I should say that view is not just mine. The Law Society of England and Wales commenting in 2017 said, the direction that Northern Ireland has travelled should be something that the English Act Review should take into consideration. Well they have, but they haven't moved. Lady Hale, writing in the bulletin last year, I can give you the reference, said, once again, I agree that the direction should be impaired decision-making capacity, and while I am trying to influence the Review Team for the English Mental Health Act Review, I think they're waiting on Northern Ireland to see what their experience is. So we are very much in a social experiment here, once the Department actually gets around to implementing it in full. 12:59 13:00 13:00

136 Q. Perhaps not for the first time, Professor.

CHAIRMAN: How are you doing for time? I am very happy to sit on if we can finish in the next 10 minutes.

MR. McEVOY BL: I am in your hands now, but I am really very close now to drawing matters to a conclusion.

CHAIRMAN: Absolutely, and you would prefer us to finish, wouldn't you? 13:01

A. I would prefer to see it through now, if you wouldn't mind.

CHAIRMAN: I understand. Okay. Well if everybody can bear with us. 13:01

MR. McEVOY BL: Hopefully 10 minutes will suffice.

Really it is, Professor, just with a view now to coming to some of the matters that you raise in the conclusion of your statement, which begins at paragraph 75. Let me give you the full opportunity now to talk about what you have set out. At 75 you say: 13:01

"It is, of course, possible to consider abuse and poor practice at Muckamore Abbey Hospital as a local problem, for which individuals and/or a single health Trust could be blamed. However, it seems to me that if this is the approach taken by the Inquiry then there is a danger that the real whole system problems will not be identified, owned and addressed, and that any findings and recommendations the Inquiry might make are unlikely to reduce, to the greatest extent possible, the risk of repetition." 13:01 13:02

So do you harbour a lingering concern that there may be a risk of an unduly sort of local focus, Professor, just on how the issues in the Terms of Reference are being approached?

A. Well, I think the long journey you've taken me on today gives me a lot of reassurance that the concerns I have for what I describe in this as "an unfortunate coalescence of factors" has been well exposed and talked about this morning. 13:02

13:03

I would just want to add one other factor that might well be worth considering, and that is the unfortunate coincidental timing of the Review of public administration and its implementation.

137 Q. The inquiry Panel may not be familiar with what that entailed. If you could summarise it in as brief a way as you feel you can do it justice and what the implications of it were, just for how things ran and now run in Northern Ireland? 13:03

A. This is quite a large piece of work carried out in 2005/06, again, under direct rule and Peter Hain was the Direct Rule Minister. There was a radical re-organisation, rationalisation, of a lot of our public sector services, health, housing, education, particularly the health sector. And it was to try and take out some of the layers of bureaucracy. 13:03 13:03

CHAIRMAN: It was the burning of the quangos or whatever it was called, yes.

A. That's it. And the significance of it is in relation

to Muckamore Abbey, before the review of public administration, I know for a fact that the hospital had cultivated a very good working relationship with its community trust, which was North and West Belfast Trust. Roy McConkey referred to it in his presentation last week. 13:04

They had arranged and succeeded in the Board's holding its meetings, its Board meeting at the Trust. So it was that kind of intimacy they were trying to cultivate. I knew the Chief Executive extremely well, Richard Black. He had a keen interest in community matters in mental health and learning disability. All that disappeared in 2007, April 2007. And you had a new Trust right at the very moment, a massive Trust, one of the largest in the UK in a situation where Bamford was just going live and where there was really no relationship between the Hospital, sitting 15 miles away, and this large Hospital Trust, with its major concerns about the two great hospitals, The Royal Hospital, The Royal Victoria and The Belfast City Hospital. I have lived through the 40-years of being in these Trusts and I know that the tension between those two Trusts about merger was in the frame for years. So when this happened, this was merger. So it was a big issue for the new Trust. 13:04 13:04 13:05 13:05

And, secondly, the regional services, cancer services, trauma services, all focusing on this new Trust.

I think, and my experience is that mental health and learning disability were down their priority list in those early years, understandably. So it was unfortunate. So I think it is a contextual matter that I think is worth being aware of.

138 Q. You then say at 76 and 77, let's take 76 first:

"I do not seek to in any way excuse or justify the abuse of patients by staff at Muckamore Abbey Hospital, nor do I seek to condone poor practices that occurred there. I also do not seek to absolve the Belfast Trust in respect of any management or other deficiencies it will be shown to have had in its running of Muckamore Abbey Hospital.

However, it must also be important for the Inquiry to reflect on a desperately regrettable perfect storm of factors may have contributed at Muckamore Abbey Hospital. This must include the fact that a single health Trust, albeit one of significant size and standing, was left to run a regional facility, including a facility with forensic responsibility, whilst at the same time trying to empty it of its patients, but without the whole system resources (not limited to funding) envisioned by the Bamford Review and agreed to by government."

So the perfect storm of factors that you have described referenced and, indeed, you discussed throughout the

course of the morning is not something, so that the Inquiry is clear, is not something that in any way should be taken to downplay or dilute any of the things that the Inquiry is looking at, the events or incidents that the Inquiry is looking at? 13:07

A. Absolutely. Absolutely.

139 Q. The Belfast Trust which has responsibility overall for Muckamore is a single Health Trust but it is not simply one of a number of, just one of a number in Northern Ireland, it is sort of a first-among-equals, if you like, would that be fair to say? 13:08

A. Because of regional services particularly.

140 Q. In addition to Muckamore, it also runs, for example, The Royal Victoria Hospital, one of those world renowned centres of excellence, so on and so forth. You would presumably want to correct any impression that may be picked up from what you have said there that the Trust saddled with this responsibility, the Belfast Trust was no Ordinary Trust, wouldn't that be fair to say? 13:08 13:08

Do you know whether your colleagues went at any time, or whether colleagues within the Trust went at any time to the Department with respect to Muckamore and said, look, this is getting too much or we cannot handle this or we need assistance. Now, I am putting it very crudely there, you will appreciate, but was the message ever transmitted that this is becoming a real issue for us and we are not sure if we are going to be able to 13:09

handle it?

CHAIRMAN: When you say "this," what are you referring to?

MR. McEVOY BL: Well I am just about to explain that to the witness. 13:09

So, what I am saying is, in terms of the decision that was taken to resettle and, as you put it, empty the hospital of its patients with all of the associated issues, do you know where there concerns about the 13:09 Belfast Trust's ability to see that through was ever communicated?

A. No, I don't think that was ever in the air. I think the issues that were in the air was the funding failures and I have pointed to other issues which 13:10 I think were operating. But I don't think people were articulating them particularly.

141 Q. Do you think it may have helped if they had articulated them?

A. Certainly. If they were experiencing difficulties, 13:10 yes, absolutely. The ability of the system to respond in the absence of a work strategy, a Workforce Strategy is an issue.

DR. MAXWELL: Can I ask you a question about that? So you talked about the importance in delivering Bamford 13:10 in preparing staff for a change in the way care is delivered. We know from the Workforce Report that 70% of the staff were nurses.

To what extent was the Director of Nursing at Belfast Trust, or the Chief Nursing Officer in Northern Ireland involved in any way in preparing for this change, or to what extent were they involved in the Bamford Review?

A. The silos of professionalism weren't really a major issue. We would have had nurses and doctors, but we didn't actually bring them, we didn't work through like the Chief Medical Officer or the Chief Nursing Officer as such. 13:11

DR. MAXWELL: But the Workforce Review says 70% of the workforce are nursing, and yet, I can't see how there was a response from Nursing to this and they are 70% of the workforce, according to the Workforce Review. 13:11

A. I agree, but we hadn't the Workforce Review. What we have laid out is what should have been happening. I made several attempts to try and encourage the Department to set-up a Workforce Review. I think in the Priorities Report there is reference to documents on ways of working which includes nursing reports. 13:11

We were aware of the insights coming in from Nursing and, certainly, the Department would have to be across professions, but also wider than the provisions, the user community and the carer community in a Workforce Strategy. You need a very multi-disciplinary group. It would be easy enough to design a process that would get a good Workforce Strategy going if they just took the initiative. 13:12

142 Q. MR. McEVOY BL: Just on that very score and following

on from Dr. Maxwell's question, what do you think it might have looked like? I mean, if it was quite simple in terms of getting the views and the input of nurses who are, as you put it earlier on, the lifeblood of the hospital there? 13:12

A. Well, you would need some sort of an overall programme team and that programme team would have to have input from the professional groups. You would have to have a representative from the Department CNO, DNO, or ask their guidance, or work through RCN. I mean, there are 13:13 accepted routes for getting representation.

143 Q. Is that something, just to be clear, is that something you feel that would have been comparatively quite simple to do?

A. Absolutely. It's do-able. I mean I spent, did 13:13 I mention already, I spent 10 years prior to the Bamford Review working on Quality Improvement Initiatives in Northern Ireland across the Trusts. We set up Quality Improvement Teams in most settings. It was in mental health, not learning disability, 13:13 unfortunately, looking back.

Nurses dominated that group and they were very, very competent. And they were very enthusiastic about improving the services and improving safety for their 13:14 patients. They were onboard with very little effort. We were actually working from the ground up rather than the top down. And that really gave me insight into change management and change processes. I was very

involved at that time with total quality management, we published on it and it was really working.

144 Q. So a similar model could have been applied or similar principles could have been applied here?

A. I think the Recovery Colleges is almost what has grown out of that in mental health. 13:14

145 Q. Professor, I have one final question really which is, I suppose, to bring your evidence to a close just in terms of the questions that I have.

13:14

With the benefit of all of your experience, extensive experience, and with the learning of the last 20-years, both within Bamford itself and then in your work subsequently on the capacity legislation, can you tell us what you think would need to be done differently to deliver the Bamford Review ambitions for people with learning disabilities? 13:15

A. Yes. Well I think addressing the gaps would be the first two things. The gaps in funding. The gaps in Workforce Strategy and all the other problems that the Review Team are clearly identifying downwind from the Department. I think this is important, not just for understanding the past, it is about preventing in the future. 13:15

MR. McEVOY BL: Professor, those are the questions that I have. It may be that the Panel will have some questions. 13:15

CHAIRMAN: No, I think, if I may say so, a very good point just to end on. Also to re-assure everyone

listening that it is important that we understand the Bamford Review. It is important we understand the outcomes of the Bamford Review, without anybody thinking that we are losing sight of our core Terms of Reference. Everybody knows very well what they are. 13:16

So, can I thank you very much, indeed, for coming to assist us and spending a bit of extra time this morning. It has been enlightening and thank you very much, indeed, for your help. 13:16

A. Thank you for inviting me.

CHAIRMAN: You can now go with the secretary. We next sit on Monday, I think, that will be at 10 o'clock in the morning. 13:16

THE INQUIRY WAS THEN ADJOURNED TO MONDAY, 3RD APRIL 2023 AT 10:00 A.M.