MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY 7TH JUNE 2023 - DAY 49

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THE HEARING RESUMED ON WEDNESDAY, 7TH JUNE 2023 AS FOLLOWS:

MS. KILEY: Good morning, Chair, Panel. This morning's witnesses are Marie Heaney, and Brona Shaw, names that the Inquiry will be familiar with, we have heard from them both before, but today they're attending to speak to Module 3 and to four specific topics in Module 3. 10:02

So for ease of everyone, including the witnesses, I will spend a bit of time identifying the topics and the relevant portions of the statement, but I intend to do that when the witnesses are sworn in and at the table so that they are also clear which topics are being addressed. 10:03

CHAIRPERSON: I think that would be really useful, because they are not necessarily -- of course -- well, one hasn't made a statement and the other has, but they are not necessarily speaking about their own statement.

MS. KILEY: Exactly, so we will spend a bit of time doing that when they are here. So unless there is anything further they can be called. 10:03

CHAIRPERSON: No, let's get them in, thank you. I think for everyone's assistance we ought to have Mr. Hagan's statements open for those who have access to them, so the first and the second. 10:03

MS. KILEY: Yes.

(Ms. Brona Shaw and Marie Heaney sworn)

CHAIRPERSON: Ms. Shaw, welcome back, and Ms. Heaney, you must feel as if you haven't left, but thank you very much as well for coming back. You know the rules, because it's quite unusual to have two witnesses giving evidence at the same time, so when one of you is speaking obviously we will treat that as the main speaker. And if there is any interruption please give your name so that it shows on the transcript who has given what evidence, as it were. Yes, Ms. Kiley. 10:05

MS. KILEY: Thank you. 10:05

MS. BRONA SHAW AND MS. MARIE HEANEY, HAVING BEEN SWORN, WERE DIRECTLY EXAMINED BY MS. KILEY AS FOLLOWS:

1 Q. MS. KILEY: Good morning, Ms. Shaw, Ms. Heaney. You have both given evidence to the Inquiry before, but just to remind everyone; Ms. Heaney, we heard from you yesterday and you confirmed that you were the former Director of Adult Social and Primary Care, isn't that right? 10:05

A. That's correct.

2 Q. And you held that post, I think, it was September '17 until 2020, is that right?

A. Until June 2020.

3 Q. And you are a social worker by way of background. 10:05

A. Correct.

4 Q. And Ms. Shaw, you gave evidence last week also on a different module. Just to remind everyone, your role is the Deputy Director of Nursing Quality, Safety and

Patient Experience, isn't that right?

MS. SHAW: That's correct.

5 Q. And you've held that role since January '19?

A. That's correct.

6 Q. And you are a nurse by background and hold live registration still, isn't that right? 10:06

A. I'm still a midwife by background, yeah.

7 Q. Whilst you have both given evidence before, as you are aware the Inquiry is dealing with a range of modules. And the evidence that you gave previously related to some of the earlier modules that the Inquiry was looking at, but today you are here to give evidence about Module 3 that the Inquiry is looking at. 10:06

And the Belfast Trust has provided two statements which were authored by Mr. Chris Hagan in respect of that module. And for reference they are statement numbers 101 and 105. Have you both seen those statements, Ms. Heaney? 10:06

A. MS. HEANEY: Yes. 10:07

8 Q. Ms. Shaw?

A. MS. SHAW: Yes.

9 Q. Thank you. And Mr. Hagan attended himself in fact to give evidence, as you may know, on 20th of April, and indeed is scheduled to return again on 21st of June. So we will be hearing from him again, and indeed others from the Belfast Trust in respect of some of the topics that he addressed in those statements. But today you are both here to deal with four specific topics that 10:07

are addressed in his statements. So I want to just look at those specific topics and identify the relevant portions of Mr. Hagan's statement that we will be looking at.

10:07

So, if I could bring up the evidence modules documents on screen please. You will shortly see a document on the screen in front of you. And if we could scroll down to Module 3 please. Thank you.

10:07

So, this morning the topics for consideration are Module 3A, Policies for Delivering Health and Social Care to Learning Disability Patients 1999 to 2021. And this topic is dealt with in Chris Hagan's first statement at paragraphs 16 to 18, and his addendum statement at paragraphs 6 to 22.

10:08

And the next topic that we are dealing with are Policies and Procedures Concerning Patients Property and Finances. That's Module 3F on the screen. And this topic is dealt with in Chris Hagan's first statement only at paragraphs 99 to 105.

10:08

The next topic is 3H, and that is Resettlement Policies and Provision For Monitoring of Resettlement. That topic is dealt with in Chris Hagan's first statement at paragraphs 192 to 207.

10:09

And finally, if we can just scroll down a little bit to

see 3M, the final topic is Policies and Procedures For Further Training of Staff Continuing Professional Development, and this topic is dealt with in Chris Hagan's first statement at paragraphs 320 to 345.

Now, Ms. Hagan [sic], if I can ask you first of all, can you confirm that you have read the relevant sections of Chris Hagan's statement that pertain to the topics this morning? 10:09

A. MS. SHAW: Myself, yes, Brona Shaw, yes.

10 Q. I beg your pardon, thank you, Ms. Shaw. And are you content that they are accurate?

A. MS. SHAW: Yes, thank you.

11 Q. Ms. Heaney, can I ask you the same question. Firstly, have you read the relevant portions of Mr. Hagan's statements? 10:10

A. MS. HEANEY: Yes.

12 Q. And are you content that they are accurate?

A. Yes.

13 Q. Thank you, Ms. Heaney. So we have discussed the logistics of giving evidence this morning. Ms. Shaw, you are familiar with the format from last week. And Ms. Heaney, I have discussed it with you this morning, but as you know we will take each topic in turn. As I take each topic I will identify a witness to whom I am primarily going to address my questions. And I would ask that that person answer the questions in the first instance. But if the other one of you has something that they feel they need to add at the end, or 10:10 10:10

something that they contribute, please interject, but wait until the first person has finished.

The other thing to try and remember, which is difficult, but I will try and help you with is, that if you are going to add something to a topic that your colleague is addressing, please identify yourself, and that's for the benefit of the stenographer so that our transcript can accurately record the evidence given by each of you, okay. 10:10 10:11

A. MS. SHAW: Yes.

A. MS. HEANEY: Yes.

14 Q. So turning then to the first topic, topic 3A, Policies for Delivering Health and Social Care to Learning Disability Patients 1999 to 2021. Ms. Heaney, I am going to primarily address my questions on this topic to you. 10:11

A. MS. HEANEY: Okay.

15 Q. And if we could bring up please paragraph 17 of Chris Hagan's first statement. That's at page 9. Thank you. And you can see there, Ms. Heaney, that what Mr. Hagan does is set out in chronological order what he says would appear to be relevant to the general topic of the provision of health and social care to learning disability patients between 1999 and 2020. 10:11 10:12

And he lists there a number of policies. There are 54 in total. And when one looks at the list we can see that many, and in fact most of those policies are

authored by the Department and are regional policies. And you may be aware that the Inquiry has in fact already heard from the Department of Health on this topic, so I'm not going to ask you to take us through those policies and speak to those. But my question to you is that whilst it's clear that the Department sets regional policy in respect of health and social care to learning disability patients, how does -- in general terms, how does departmental policy migrate down to Trust level, and how does the Trust ensure that it delivers the departmental policy objectives? 10:12 10:12

A. MS. HEANEY: Well, in my experience once the Department set a strategy or a policy document, it is the responsibility then of -- obviously everybody has access to it and, you know, consumes it and understands it and has thought it through. But normally the process is that it then goes to the Commissioning Board, SPPG now, and it's their responsibility to formulate a commissioning statement. 10:13

I mean there will be many aspects to a policy, and they are usually broken down into various sections, commissioning statements are drafted and action plans developed. And then, you know, there is -- in my time there was a business case then had to be responded to by the Trust on each aspect of that strategy and funding agreed or not agreed, you know, so there was a whole process of conversations and discussions between the Commissioning Board, now SPPG, and individual 10:13

trusts about what the expectation of the Commissioner was. It is the Commissioner's role to understand the needs of the population, to have described them, to have outlined in some detail what the outcomes of such -- of this policy is. And then there is a process between the Trusts and the Boards to understand what funding is available.

The Trust need to also describe what services currently are in place and how they may need to change, any public consultations that might be required, you know, if, for example, if there is a need to change a service or close a service that is no longer evidence based. So there are conversations between service heads and the planning and contracts team and their opposite numbers in the Commissioning Board. And in my experience that's how it evolved.

And once the investment was agreed, the money was drawn down from the Board and then the Trust began whatever recruitment, implementation planning, and understanding the constraints, developing solutions to those constraints. So there was a fairly long and detailed process, you know, to get from policy to the realisation of that policy into an effective service on the ground.

16 Q. MS. KILEY: Yes. And the conversations that you have spoken about there, is it right to say that they happened after the departmental policy was set?

A. Yes, the formal processes would have happened after the policy.

17 Q. Does the Trust have any role, for example, by way of consultation on the Department's development of regional policy? 10:15

A. Yes, they do indeed. I mean the Department's approach usually is a fairly broad consultation process that involves all the stakeholders, including the Trust. So the Trust would have an opportunity to comment on the policy. It may not be taken on board, but, you know, 10:16 the Department always in my experience have consulted fairly widely.

18 Q. Yes. So is it fair to say that whilst a number of those policies that are listed in Mr. Hagan's statement are departmental policies, the Trust would probably 10:16 have had an input into the development of those?

A. Yes, absolutely.

19 Q. Now, I think I said there were around -- there are 54 policies that are listed there. There are three of the documents that Mr. Hagan refers to that I want to look 10:16 at with you and ask you some questions about. I know you may not have all the exhibits in hard copy, but I'll bring them up on the screen.

So the first is the policy that is -- it's in fact a 10:16 piece of legislation that is listed at paragraph 17H of Mr. Hagan's statement, and that is the Health and Personal Social Services Quality Improvement and Regulation Northern Ireland Order 2003. And that

appears at page 000445.

Ms. Heaney, while we are waiting for it to come up on screen, I can tell you what I am about to bring up is section 34 of that piece of legislation, which sets out the quality duty on the Trust. Are you familiar with that quality duty in general terms? 10:18

A. In general terms.

20 Q. And setting aside the language of the legislation, which we can look at shortly, are you able to tell the Panel...there we can see it now. So can you see the legislative duty there is set out at section 34. 10:18

A. Yes.

21 Q. "Each Health and Social Services Board and each HSS Trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal Social Services which it provides to the individual and the environment in which it provides them." 10:18

Now, that is a wide duty. And I just wondered if you could explain to the Panel any more about what the Trust understands it's quality duty to be in practice?

A. Well, I think the legislation for the first time, you know, placed a duty of quality. So in my understanding, in my service areas, it was really trying to have in place evidence based services, that you were able to, as far as the evidence allowed you, to demonstrate that it was an effective, as well as the 10:19

service user experience was good. It's all of those domains of quality and effectiveness that are embedded in many of the governance -- the governance systems and processes. That's my general understanding of the obligation.

22 Q. And how in general terms then does the Trust seek to meet that duty?

A. Well, there is a number of ways, I mean, I think there is service reviews. I mean, you know, I remember from my own experience looking at the experience of people in residential care, and that model of care for -- you know the buildings were no longer suitable, the model of care did not promote independence, you know, there was quality issues that didn't meet the regulations, the room sizes were, you know, no longer suitable for today's expectations. So there would be a number of key performance indicators, key quality indicators for specific services that demonstrated the service really was no longer fit for purpose and needed to transform or change.

Or if, you know, there was negative feedback from service users, you know, there is various indicators across the governance systems and process that flagged concerns about quality issues and services.

I mean, we would have staff who do quality monitoring, and that is largely about talking to service users about their experience of the service. We would use

the complaints, you know, gather up the information from complaints. So there would be an overall Trust framework for identifying and responding to quality issues in services that were no longer fit for purpose. And then there would be other processes, either to improve or close those services. So that's in broad general terms my understanding of the duty to quality.

CHAIRPERSON: Could I just ask, do those key quality indicators match anything that the RQIA are doing?

MS. HEANEY: They would be broadly similar. RQIA have very, you know, specific domains. I think from memory like it is about leadership, safety and effectiveness. And when they are doing their inspections they would look for certain evidence that would support that, and the Trust had similar, they were broadly similar. 10:21

23 Q. MS. KILEY: And who sets those key performance indicators in the Trust?

A. Usually they are set out by either the Department or the Board. I mean each local service, you know, may have their own, they would adapt them for their own use, but generally they are set at a very high level. 10:22

24 Q. I want to turn then to the next document, and this is the policy that is mentioned at point X of Mr. Hagan's statement. This is in October 2009, Royal College of Psychiatrists Standards for Adult in-Patient Learning Disability Units, first edition, and this appears at page 915 please. 10:22

That should be on your screen now, Ms. Heaney. So as

you can see this is a Royal College of Psychiatrist's document entitled Accreditation for In-Patient Mental Health Services, Learning Disabilities, Standards for Adult In-Patient Learning Disability Units.

10:22

And if we could scroll down then to page 918 please. You will see there is a foreword there. And in the third paragraph of that it explains who the standards are applicable:

10:23

"These standards are applicable to any in-patient unit that supports adults with learning disabilities who present with mental health needs, challenging and/or forensic type behaviours. The exception to this are those units considered to be homes for life. A similar 10:23 document of standards also already exists for children with learning disability."

And if we scroll down then again to the next page please, 919. And just pause there, you will see that 10:23 there is reference to the need for a quality improvement programme. And there is reference to some of the challenges that exist in residential provision for people with a learning disability.

10:24

And if we just scroll down please to the final paragraph, you can see there it says:

"In England NHS managed long stay LD units. Have

attracted the attention of the media and of the Healthcare Commission, because poor standards of care and of institutionalised practices that created a culture where abuse was more likely to occur.

10:24

"Recent, high profile press coverage has dented public confidence in adult learning, disability in-patient units in general.

"The Learning Disability Faculty discussed at length what the college could do, both to improve the quality of care and to demonstrate that care practices in these units are generally sound.

10:24

"As a result, it asked the college centre for quality improvement to develop a new standards based quality improvement network for in-patient units for people with learning disabilities and mental health needs."

10:24

And if we scroll down then to the next page 920, you can see there that there are some key principles. And if you could just zoom out so we can see that whole page please. And if you just look under that heading "membership", you can see:

10:25

"Membership is open to any LD unit that is managed by either the NHS or the independent sector. The common criterion is that the care received by the residents of the unit is funded by the NHS."

And then below there is below that standards and associated criteria. So it appears that this is a document setting out an accreditation process.

And I wondered, there is -- this document is the 2009 document. To be fair, Mr. Hagan also provided an updated document, which is dated 2016. But my question is a general one, Ms. Heaney: Has Muckamore Abbey Hospital ever held accreditation? 10:25

A. It has actually, and I think for one ward, now, I don't recall the detail of it, but certainly when I was in post I was made aware that one of the wards had achieved accreditation, and I think it was for the assessment. And I can go back to the psychiatry colleagues and check that, but there was one of the wards had accreditation. 10:26 10:26

I mean obviously not being psychiatrist, you know, I haven't a huge insight into the standards and how they may have been applied. But what I do know is that the medical director's office in the Belfast Trust holds, I think, its annual, or perhaps biannual, but certainly regular meetings with the medical teams, including the medical team in Muckamore. And they are required to really present information to the medical director about the work they have been doing, the challenges they are facing and their standards they are trying to work to, and any issues they may have. 10:26 10:26

So there would be a long, you know, record of the medical team in Muckamore reporting to the medical director.

So each professional would tend to account for their practice and issues through their professional, and it is the same for nursing and social work. 10:27

25 Q. DR. MAXWELL: But I think the standards, and certainly the later versions have been developed as an MDT approach? 10:27

A. Yes.

26 Q. DR. MAXWELL: Certainly the RCN has been involved with the Royal College of Psychiatrists in the CAMHS units, for example.

A. Yes. 10:27

27 Q. DR. MAXWELL: But there is a cost associated with accreditation. In your time as the director, were you ever asked to fund participation in an accreditation for Muckamore Abbey?

A. No, but what I -- the answer is, no, I wasn't. But I do know that I worked with a team of some of the members of the team to pursue benchmarking for learning disabilities, including Muckamore. 10:27

28 Q. DR. MAXWELL: And who was doing that benchmarking, which organisation? 10:28

A. It was a large UK organisation, whose name escapes me at the minute. But I mean I was very keen that the learning disability joined that national accreditation so that we could begin to standardise systems and

processes and expectations. And we did collect a lot of data for the first year. But colleagues in mental health in Belfast went through that process and it made a tremendous difference to, I think, the standards of service and the cultural changes that were needed in services, and I was very keen that learning disability followed that as well. 10:28

29 Q. DR. MAXWELL: If I could clarify, you did you collect data about learning disability services to use in a UK-wide benchmarking exercise? 10:29

A. Yes. Now, it was only at the very start, so I'm not sure where it went after that, but...

30 Q. DR. MAXWELL: Did you see any initial reports on where the learning disability services sat in relation to others in this benchmarking exercise? 10:29

A. No, it was the first year, I think, you know, the Covid interrupted that. What I did see was the organisation sending information back for validation. So it was in the very early stages, but certainly the team at that time were very keen to pursue that because it there was just lack of consistency. 10:29

31 Q. MS. KILEY: Ms. Heaney, you may want to check this, but does the time the quality network for learning disability, does that ring a bell?

A. It does ring a bell, yes. I mean the team in Muckamore had pursued accreditation for one ward, as I said, and achieved it. 10:29

32 Q. Yes. So going back to that, the accreditation that was achieved for one ward, can you recall at what period of

time that was achieved?

A. I think that would have been -- it was fairly recent, I think that would have been '15, '16, that sort of... I'll certainly go back and check that.

33 Q. And the national benchmarking process that you just referred to, was that a different process? 10:30

A. Yes.

34 Q. And at what period of time did that take place?

A. Well, we started that in '18/'19. I mean that was more service as opposed to clinical, you know, it was more a service-wide, you know, the models of service and the configuration, the data and the numbers. 10:30

35 Q. The document that we just looked at is dated 2009, so it appears that the Royal College of Psychiatrists introduced the accreditation process in 2009. Is there any reason why Belfast Trust didn't seek accreditation for Muckamore before that 2015, 2016 period? 10:30

A. I am very sorry, I can't answer that, I just don't know.

CHAIRPERSON: Could I just ask, you said that a lot of data was collected, was that for the purposes of the accreditation? 10:31

DR. MAXWELL: Benchmarking.

A. MS. HEANEY: Benchmarking.

CHAIRPERSON: But you said it's made a tremendous difference to the standards of service. What was it that made the difference to the standards of service? 10:31

A. MS. HEANEY: Well, in adult mental health services, which was a different division, the team there, the

senior leadership team there had, you know, several years prior to me learning about it, they had engaged in that process. And they just -- they used to report at team meetings how useful it was and how it had helped them change services.

CHAIRPERSON: And was that leading towards accreditation? Sorry, Dr. Maxwell, she knows more about this, much more than I do, but I just want to understand where the accreditation --

A. MS. HEANEY: I think it is just a performance monitoring tool that allows an organisation to see where they are in relation to all other say mental health services across the UK.

36 Q. DR. MAXWELL: And I think they match and work with better performing organisations, and that's where the learning comes in?

A. MS. HEANEY: Yes, I mean, that was very attractive, I mean the teams were able to go and visit other mental health services and...

CHAIRPERSON: So you could then benchmark to see how others are doing it?

A. MS. HEANEY: Exactly, and that's hugely healthy for services.

CHAIRPERSON: I may be the last one in the room to have understood that. Thank you.

37 Q. MS. KILEY: Thank you, Ms. Heaney. I am going to move on to another document that I want to look at with you, this is the last one that I want to look at in detail, it's at page 1594 please, and this is referred to at

part LL of Mr. Hagan's, paragraph 17, service framework, set up by the DHSSPS in January 2015.

So you can see there, it should be on the screen in front of you, this is the DHSSPS Service Framework for learning disability, and this is the January '15 version. Now, we have heard -- are you familiar with this document, Ms. Heaney?

A. MS. HEANEY: Yes.

38 Q. And you may or may not be aware that the Inquiry has heard from the Department of Health on this matter and has heard that the service framework has been in abeyance since 2018. Were you aware of that? 10:33

A. I wasn't aware that it was officially in abeyance, you know, when I was in post I assumed it was still applicable and the team still looked to it. 10:33

39 Q. Well, I will ask -- I want to ask you a little bit more about how the Trust operated it, but if we look firstly at the document. If we could scroll down to page 1596 please. And if you can just zoom out so that we can this whole page. 10:34

CHAIRPERSON: This is when Edwin Poots was minister?

MS. KILEY: Yes. And this is the foreword by the minister. And in the third paragraph you'll see he says there that: 10:34

"Service frameworks claim to set out clear standards of health and social care that are both evidence based and measurable. They set out the standard of care that

service users and their carers can expect. They are also to be used by health and social care organisations to drive performance improvement through the commissioning process."

10:34

I just want to pause there, Ms. Heaney. You will see the reference there to setting out the standards of care that service users and their carers can expect. And I just wondered, did the Belfast Trust provide this document to families of patients routinely so that they knew what they could expect? 10:34

A. I really don't know, and I apologise, I don't know if families were provided with this. I mean what I do know is that, you know, that -- I think it is about 34 standards, 30 that applied to trusts. 10:35

There was a period of time spent collating data that would demonstrate adherence to the standards. I mean one of the issues most trusts have to deal with is information systems, you know, that are different. So there was a difficulty in, you know, collecting the information that could be used for comparison purposes. 10:35

But I can certainly find out if carers were -- I would suspect they were, but I can't confirm it because I wasn't, you know, around the service at this time. But they were generally considered to be extremely useful standards that could guide service development. 10:35

I remember one in particular was where individuals with a learning disability could get an annual health check, and that the Trust's learning disability community nurses would support clients to visit their GP and get a full health check, particularly, you know, patients who may have co-existing conditions, maybe diabetes or epilepsy, or maybe couldn't articulate their health needs, bring them along to the GP and get a full, you know, health check and maybe a health action plan. 10:36

So it was generally considered very positive. So I think trusts generally in Northern Ireland embraced the standard. Now, there was some that were less able to be achieved, I can't remember them all at the minute, but I think one of the challenges was that every trust had different models of learning disability teams and there was no commonality between the configuration of the teams, how the positive behaviour support models worked. The composition of teams, how they accepted service users into teams. 10:36 10:37

So, I think, there was a general frustration that there was no single model of learning disability for the community trusts. So inevitably trusts interpret them and modify how they configure, probably based on what has always been there. 10:37

40 Q. Yes. So this is -- the document that we are looking at is a regional document?

A. Yes.

41 Q. But are you saying that it might have been put in place in different ways in different trusts --

A. Yes.

42 Q. -- because of their different --

A. Well, just historical patterns of service delivery. 10:37
And, you know, the challenge of standardisation was always there. I mean I have been involved in other services where there has been a strong regional drive to standardisation. I always found it very, very helpful, because you develop a collaborative model of 10:37
working with other trusts rather than competition. And there was a lot of inter-trust learning. And ultimately, I believe, it improved services for people -- you know for patients.

10:38

For example, I was involved, you know, in various ways in the stroke services and reablement services, you know, they were all centrally driven. And I think that's helpful. And the general feeling was that a single model for learning disability, given the 10:38
relatively small number of patients, you know, every Trust would probably have in the region of maybe 800 to 1000 patients -- you know service users that are in touch with the Trusts, that it seemed a relatively small number. 10:38

Now, I understand that the Department does have publication ready to be published on a single model.

43 Q. I am going to come to that actually. Ms. Heaney, I

will ask you about that. But thinking of the introduction of this document, in your experience did this help lead to standardisation of service in the Belfast Trust?

A. I think to a certain degree. I think from the last -- I mean obviously you probably are aware that RQIA did a review of the service standard framework work at a point in time and found that maybe 25 or so of the service standards were met in all of the Trusts, but the rest of them were not. And I think there was a need to integrate the children's, the transitions to create a more life-long pattern of services that reduces the shock of transition, you know, if you like. 10:39 10:39

So, I mean, I think, trusts generally welcomed them and they proved a mechanism to drive change where it was needed. 10:39

44 Q. And those mechanisms, I think, it's fair to say were very specific. If we can look at an example, for example, at page 1636 please. I'm not going to go through all the standards, but I think this is Standard 1. And as you can see, all the standards appear to take this format. So the standard is set out, and there is service user perspective, a rational. And if you could scroll to the next page please. You will see the evidence base supporting the standard is set out. And keep scrolling down please. And then you will see we come to the heading "Responsibility for Delivery Implementation and Delivery and Implementation 10:40 10:40

Partners". So the standard sets out who is expected to deliver the standard and who that person may be in partnership with.

And then scroll down again please. And you can see there that performance indicators are set out in that table, performance indicator, data source, anticipated performance level and date to be achieved by. So there are specific targets that are given to trusts to meet, and indeed specific dates by which they are expected to meet them. 10:40 10:41

And I wondered can you assist the Inquiry, Ms. Heaney, with, who did the Trust have to account to for meeting these standards? 10:41

So not necessarily honing in on that specifics example, but I am showing you that just generally to demonstrate that it appears that these were very specific standards and trusts were given specific times to implement them. So who did the Trust have to answer to as to whether they were implementing them? 10:41

A. My recollection, I would need to double check it, was the Board, you know, the SPPG, not the Trust Board, but the Commissioning Board. And I am drawing that just from my own experience that the Board had an oversight of the service standards. 10:42

I mean RQIA came in obviously and did reviews of the

standards and were able to feedback to the Commissioning Board then about how far Trusts were getting on.

45 Q. But that accountability from the Belfast Trust to the Regional Board, the SPPG or the HSCB, as it was then, how did that work in practice? Can you tell the Panel how often the Trust reported to the Board on these matters? 10:42

A. I am afraid I just don't recall, I was never involved directly in meetings. Normally there would be regular meetings between the Commissioning Board and Trust teams, and a range of topics would be covered, and this may well have been one of them. But if it's helpful to the Inquiry I will go back to the service and ask for the evidence of that, but in my general experience it would be through the contract meetings. 10:42 10:43

46 Q. And in your experience are you ever aware of an occasion where action was taken against the Trust because it wasn't meeting a standard?

A. I mean I do recall many robust conversations, usually around the availability of resources and so, but I cannot recall -- I presume you mean a punitive action? 10:43

47 Q. Yes.

A. I have no recollection or experience of that.

48 Q. And I mentioned to you that the Inquiry has heard evidence that this framework was in abeyance from 2018. And I wanted to ask you how that affected the Belfast Trust's delivery of its learning disability service. I think what you said earlier was that you continued to 10:43

work with these standards. Can you explain a little bit more about that to the Panel please?

A. Well, I am afraid I can't explain too much more. But my understanding when I was there, I was unaware that they were in abeyance. I was aware that staff, particularly the service delivery units in the community were aware of the service and worked to them.

49 Q. And can you speak to the period of time that that went on for?

A. Well, during my period of time I was aware, because when I had conversations with teams they were referred to, you know, from time to time, and particularly some of them had difficulty meeting them. One of them, as I recall, was meeting complex health and social care needs in the community, and particularly around individuals who had mental health difficulties, people with learning disability and mental health difficulties; they were unable to access, you know, core mental health services, for example.

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So, if somebody with a mild intellectual disability became clinically depressed or developed psychiatric symptoms of one sort or another, there was no services in the community really to respond to that. And the convention was that they did not access main stream mental health services. So that's using that as an example that they felt that they couldn't progress that. So very often these individuals ended up, or were admitted to Muckamore. And very often that was

10:45

perhaps not the best environment.

So there was these kind of constraints, system constraints to meeting all of the standards, but my recollection is that the teams were very aware of them and worked hard to gather the data and implement as many as they could.

CHAIRPERSON: So even though the framework may not have been refreshed or republished, as it were, you would continue to work to that framework? 10:45 10:46

A. Yes, because they were good. You know they were considered to be useful standards. I mean teams need to know that they are working to an evidence base and that they are supported by the Department and the Board in carrying out ways to work. 10:46

50 Q. MS. KILEY: You did mention there a document that the Department has ready to go, and I think you were perhaps referring to the "We Matter" document, is that right?

A. Yes. 10:46

51 Q. I want to look at that now. Mr. Hagan refers to this in his second statement. So if we could bring that up please. That's statement 105, page 6 please, paragraph 12. 10:46

So you can see at paragraph 12 here Mr. Hagan refers back to his reference to the service framework for learning disability, which we have just looked at. And he goes on then to explain at paragraph 17 to 19, the

development -- work towards the development of a new model.

And you can see there at paragraph 17, if you can scroll down to that please. That's it. You can see that he says there that: 10:47

"For a number of months until September 2019, there was an extensive engagement and consultation process with service users, families, carers and other stakeholders across Northern Ireland in order to obtain a firm understanding of their lived experiences and to seek their views as to which services should continue, which services should cease and which new services should be considered for introduction." 10:47 10:48

And then if you scroll down to paragraph 18 there he describes how the various trusts project leads worked closely to process and analyse the feedback received from the engagement and to develop and structure a number of new and innovative evidence based priorities for the new model." 10:48

And he describes what some of those were. But then at paragraph 19 he says this: 10:48

"Despite the development of a number of draft models as a result of this work and feedback, unfortunately no version of the new regional adult learning disability

service model could ultimately be agreed between the HSCB and the Trust project leads."

Are you able to explain any more, Ms. Heaney, about why that was the case? 10:48

A. I am not, I mean because obviously this happened post my retirement. But when I was in post, I mean there was huge positivity; I was involved in some aspects of the process, and there was a general agreement that a single model of learning disability was absolutely 10:49 needed and there was a huge consensus around that.

52 Q. Was it the intention that that new model would replace the framework that we have just looked at?

A. Well, I think it should be complimentary, I mean the standards are there to provide very specific standards 10:49 that are measurable and can be, you know, improved on if evidence changes. But the standards are separate to a model, a model really sets out how a service should be configured, what are the key elements that respond to the needs and wishes and aspirations of people with 10:49 a learning disability. And the problem was that every Trust in Northern Ireland had different configurations of teams, different priorities, different metrics. They were broadly similar, but not similar enough to provide the benchmarking and the holding to account and 10:50 the quality of service. So it was very much seen in that light. And many of us had visited sites in London and other parts of England, you know, Commissioners and Trust representatives to look at their service models,

the 2015 English model, which was very good, and the east London team were able to send set out to us the difference that it made in that area, which is a hugely populate area, a very diverse population with many challenges, but that it brought multidisciplinary teams together, created a common culture. You know absolutely rejected in-patient care for learning disability, there is no evidence base that in-patient, apart from maybe a very tiny, as I understood it. 10:50

So that was very exciting. And on that basis there was a process then to -- I mean the 2005 Equal Lives documentary remains the most inspirational document, I think, for learning disability and to build a model around that or learning from other models in England, Scotland and Wales. So I was surprised to read that, and I don't really understand the dynamics behind that. 10:51

CHAIRPERSON: I'm sorry to interrupt, but looking at east London, presumably the catchment of east London would be considerably greater than the Belfast Trust? 10:51

A. Yes, absolutely. The whole region maybe.

CHAIRPERSON: I wasn't going to say that, but I thought that might be...so it would be over a million.

A. So I think from what many of us took away from that learning was that the evidence base is there, there is service models that we can learn from, and it shouldn't be beyond, you know, our capability to create a regional model. And I think that was the excitement behind that. And I retired since then, but I have been 10:51

trying to keep an eye out when the model would be, presumably it was Covid interrupted as well and...

CHAIRPERSON: Yes, of course.

53 Q. MS. KILEY: And you have referred to the We Matter document. You can see Mr. Hagan says at paragraph 21 that he was aware of the final draft of the We Matter Learning Disability Service Model for Northern Ireland was formally presented by the HSCB to the Department of Health in October 2021. Were you aware of that? 10:52

A. I am aware of it now, post my retirement, but certainly I have read it. 10:52

54 Q. And in fact the Inquiry has heard from a witness from the former Health and Social Care Board in respect of We Matter. But is it right to say then that that We Matter document was not the final -- was not the outworking of that consultation and engagement process that Mr. Hagan described and which you were involved in, it was a different document, is that right? 10:52

A. Well, I haven't read the document in detail, but my recollection of the conversations that were occurring with carers and staff, you know, right across the region, was that, there needed to be a life course approach to the framework, a new model. It had needed to be sustainable, that it needed to be common across, so that I haven't actually looked in detail at the We Matter document, I have scanned it, you know, it still hasn't officially been signed off by the Department. 10:53 10:53

55 Q. Okay.

A. And presumably there will be a further consultation.

56 Q. Thank you, Ms. Heaney. Those are all the questions I have about that topic A for you. So, thank you for those. And I am going to move to ask Ms. Shaw some questions now about topic F, Policies and Procedures Concerning the Property and Finance of Patients. 10:53

So, again Ms. Shaw, I'll direct my questions primarily to you, but Ms. Heaney if there is anything that you want to add please do. 10:53

That takes us back to Mr. Hagan's first statement, if we could bring that up please at page 101. Sorry, paragraph 101, page 53.

So you will have seen, Ms. Shaw, that Mr. Hagan sets out a number of policies and procedures concerning the property and finances of patients. And he sets out a number of regional materials at paragraph 101 of the statement. But he then also provides a policy, which is said to be the one which is likely to be of most interest to the Inquiry, and that is the Belfast Trust's own patient finances and private property policy for in-patients within mental health and learning disability hospitals. 10:54 10:54 10:55

So I want to look at that with you now please, and it's at page 010031. So that's on the screen in front of you now, Ms. Shaw. It's dated 2015. And from the list of documents that Mr. Hagan has provided it appears to

be the First Trust specific policy on patient property and finance. You're nodding, is that right, was it the first one?

A. MS. SHAW: It was the first one from the legacy Trust, so the Muckamore Abbey Hospital would have followed the legacy document of 2007, and that's referred to in that paper. 10:55

57 Q. So before this 2015 policy was introduced the management of patients valuables at Muckamore Abbey Hospital would have been managed under the 2007 legacy policy? 10:56

A. Yeah.

58 Q. And to be fair to you, you will have seen Mr. Hagan's statement refers to this 2015 policy as now having been superceded. But I just want to look at this policy to clarify some specific matters with you. So if we could scroll down to page 10033 please. I just want to look at some of the roles of people under this policy, Ms. Shaw. 10:56

10:56

So you can see there that -- sorry, just scroll up to the bottom of the page before. Yeah, you will see there at Section 3, roles and responsibilities. And the roles and responsibilities of very specific people are set out. So we can see there operations managers and senior nurse managers. And if we scroll down please it says that operation managers must ensure that -- there are three bullet points there: 10:57

"Staff are aware of the management of patients' finances and private property policies and procedures.

"They provide staff with guidance regarding the implementation of this policy. 10:57

"Monitor the implementation of the policy and procedures within their service area."

Then there are other roles for charge nurses and ward sisters, and they are: 10:57

"To ensure that the policies its procedures are made available to all staff.

10:57

"Staff have an understanding of the policy and its procedures, and have filled in the policy template confirming this.

"The policy is fully implemented within their area of responsibility. 10:57

"The policy forms part local induction arising in relation to this policy are discussed at ward meetings or supervision sessions. 10:58

"Any issues not resolved should be escalated to their line management.

"And it is the responsibility of all staff within mental health and learning disability services, Belfast Health and Social Care Trust, to adhere to this policy."

10:58

And you can see if we scroll down again there are further roles of community social worker and staff member. I won't read them all out, but it appears that the policy places significant roles on individuals at different levels. And I just wondered how the Trust assured itself that those individuals were meeting their obligations under the policies? 10:58

A. Okay, so, I suppose, I mean, the 2015 predates my time in the Belfast Trust. And for today I haven't considered how assurance was given around that policy specifically. I know that there are mechanisms in place now, assurance mechanisms for patient finances in Muckamore Abbey. 10:58

59 Q. What are those mechanisms now?

A. So, I suppose, just to give a little bit of clarity; the management of patient finance sits across the whole of the Trust and not only in learning disability. So there are two policies that apply to patient property and patient finance. 10:59

10:59

The first one is the management of patients' handed in property, and that's a broader policy. That would apply to the acute side of the hospital as well -- the acute side of the Trust as well.

In that policy it talks to the management of monies or valuables that patients bring with them on admission to hospital.

The second policy then is the patients' finances and private property for adult in-patient and learning disability hospitals. And this is a much weightier paper, I suppose, and outlines very clearly and in much more detail compared to 2015, the various roles and responsibilities held by different functions within the Trust, including finance teams. 10:59 11:00

The second policy that I have referred to sets out, I suppose, and differentiates the difference between the patient type or the profile of the patients between the two hospitals. 11:00

The second policy deals in much more depth around capacity issues and where patients maybe are not able because of their condition to manage financial matters independently. And while not all patients in Muckamore Abbey are detained there is also reference to the Mental Health Order and how that is applied within the management of patient finance. 11:00

11:01

And the difference as well then would be that these patients are longer term patients and many would be in receipt of benefits. So how that income, if you like, for patients is managed securely.

The assurances around that then have been -- and the policy sets out the templates that are used.

60 Q. Can you tell us the date of that policy, I know it's the one that you are saying is presently in place?

A. Yes, so this policy was approved in 2021, and I understand that it followed a review by RQIA, where four improvement notices were required, and they have been built-in around making the management of patient finance in Muckamore more robust. 11:01

61 Q. Okay. 11:02

PROFESSOR MURPHY: I think it's the one that is referred to in paragraph 105?

62 Q. MS. KILEY: Yes, thank you. I think Mr. Hagan has provided more updated policies...yes, paragraph 105 at bullet point A. But just in general terms, Ms. Shaw, you referred to it being developed as a result of RQIA feedback. This Inquiry has heard that complaints from some patients' families about the way in which the patients' property and finances were managed at Muckamore. 11:02 11:02

A. Yes.

63 Q. Were those complaints, or any complaints that the Trust received as part of their complaints process used to feed into the new policy?

A. Absolutely. I mean any learning from complaints and reviews is always used to inform policy development, so that will have been considered if they had been received. 11:02

I know that prior to this policy there were systems in place where records were maybe maintained on the ward, or patients cash was maybe kept in a locked drawer on the ward. And things like that changed after the equip from RQIA to make it much more robust, and that patients would have a much more, I suppose, agreed way of how their money would be spent, how it was recorded, who was responsible for that, who oversaw that, how frequently that was audited. And any learning, any discrepancies that came from that would have been escalated. So, I suppose, the newer policy was much more informative for staff and gave much greater guidance to staff in how to manage patient finances more safely. 11:03 11:03

64 Q. DR. MAXWELL: Can I just clarify, you're saying that before this policy in 2021, it was common practice for cash to be kept in a locked drawer on the ward? 11:04

A. Not all cash, no, there was always the cash office and large amount of monies. But smaller amounts of money for the patient to use maybe at the tuck shop and things like that would have been kept in the drawer. 11:04

I know another practice that happened was they maybe would have done bulk purchase. So they would have gone to the shop and bought, you know, taken maybe some money from, you know, a couple of patients and bought in bulk for those patients, and that's a practice that doesn't happen any more either. 11:04

65 Q. DR. MAXWELL: And prior to 2021, in this new policy,

was there a policy around the keeping of money in a drawer on the ward?

A. No, it was custom and practice, I think, I mean there's nothing in the old policy around that. There was a record maintained of that, so, you know, the money was -- if you took money from that place would you have written and written, you know, whose money it was and where it was taken from.

CHAIRPERSON: So would each patient have an envelope or... 11:05

A. I think it was something like that, yeah. It wasn't large amounts of money, you know, it would have been, I suppose, money for the cosy corner or the tuck shop, if they wanted to go and buy themselves, you know, some crisps or something like that. 11:05

66 Q. DR. MAXWELL: And if family brought money in for that purpose and gave it to the staff on behalf of the patient, would a record be kept of that?

A. So that would have been maintained on that record that was kept in the drawer, so there was additional -- 11:05

67 Q. DR. MAXWELL: So is this a cash book or something?

A. Yeah, something similar.

68 Q. DR. MAXWELL: With numbered pages so you could check?

A. Yeah. But any large amounts of money -- this would have been, you know, short change. Any larger amounts of money would have been maintained in the cash office. 11:05

69 Q. DR. MAXWELL: And was there any definition of what a large amount of money was or was that discretionary?

A. Not that I can clarify, no.

70 Q. MS. KILEY: And did the Trust only become aware of these issues and custom and practice as a result of the RQIA equip?

A. Well, I know that the RQIA equip just highlighted it as being a practice that should be stopped. So I don't know if there had been any previous conversations. 11:06

71 Q. In terms of -- is it the case then that there were practices in terms of patients property and finances that were happening at Muckamore that weren't governed by a wider Trust policy, and that weren't being overseen by any members the Trust beyond the ward staff, is that correct? 11:06

A. No, my understanding is that the policy was adhered to and monies were kept by the cash office and any benefits were received, if the Trust was the appointee by the cash office and maintained in the account for the patient. And the smaller amounts, the only practice that I know of was the smaller amounts of cash that were kept on the ward area. 11:07

72 Q. You referred there to the cash office and we can see mention to the role of the cash office in relation to some of these policies. I asked Mr. Hagan about this whenever he appeared last time. Are you able to explain anything more about what role the Trust's cash office does have in the management of patient finances? 11:07

A. Yes, I suppose, the cash office or the patient bank is on site, okay. And it is a facility where cash or valuables can be held on behalf of the patient, by the patient who is in the hospital. It would also be

responsible for receipt of the patient benefits and handling of any patient finances.

The cash office or patient bank will look after the patients by operating a separate bank account for them and administration of their finances, maintaining an individual computerised financial ledger. And it facilitates any cash withdrawals of patient funds that are held at ward level and a secure facility for valuable property. 11:08

73 Q. And how are those practices and arrangements communicated to patients and their families. So if a patients is admitted to Muckamore and needs to use the bank, how do they know what's going to happen to their money? 11:09

A. So that is all done between -- there is now a finance officer and social worker. So on admission to the hospital, that would be explained very clearly to the patient, if the patient has capacity, and their family, or for the responsible person for the patient. And the admission details are outlined in the new policy. There is also a template at the back of the policy that allows for a structured conversation, and that's laid out in a way that the patient can be involved very much in that decision making. 11:09

And that would be where the Trust is appointed to be responsible for the patient finances. In some cases the families maintain that authority.

74 Q. Yes. That role of financial officer and that explanation that you said took place, is that a new role that has been created as a result of the new policy, or was that role in existence before 2021?

A. I'm not sure if it's a new role, it isn't highlighted in the older policy. Whether it's just been explained in the second one, I would have to clarify if it didn't exist or if it's new. 11:10

75 Q. Okay. And just on the general point about communicating policies to patients and their families; the Inquiry has heard about a staff hub that's where staff can access relevant policies, so if I am a member of staff at Muckamore Abbey Hospital, I can go on the staff hub and access relevant policies. 11:10

Is there any equivalent for families, how do they understand which policies apply to them or apply to their loved ones whenever they are in Muckamore?

A. I am not aware that there is an equivalent access point for families. The policies would be made available if they were requested. 11:11

76 Q. Is that only if they are requested?

A. Yeah, I mean, I am sure that -- I can't be confident, but I am sure in that conversation that we spoke about a minute ago with families the policy would be referred to and would be made available, but I would have to check that that was definitely the case. 11:11

77 Q. I could see you nodding, Ms. Heaney, is that your understanding too?

A. MS. HEANEY: Yes, I don't think there is, you know, a hub in the same way, but on request. It's usually in my experience the ward -- the charge nurse or ward sister would be the key person to explain the policy and the practice for families or for patients. That was a primary point of communication in my experience.

78 Q. DR. MAXWELL: Does the Trust not put any general policies on its open website?

A. Yes, there are. I mean to the best of my knowledge on the Trust website, the external website, I think there are policies. I will need to check that, but there would be some access, I mean corporate documents are all available on the website, but whether families would know, you know... 11:12

A. MS. SHAW: To navigate that. 11:12

A. MS. HEANEY: To navigate that would be another question, yeah.

79 Q. PROFESSOR MURPHY: Presumably when patients are admitted with their family members there is a kind of standard pack of information given to them? Would it include reference to where to find policies? 11:12

A. MS. SHAW: I wouldn't know, I would have to check that and come back to you.

80 Q. MS. KILEY: Ms. Heaney, are you aware of that, no?

A. MS. HEANEY: No, I am not aware of a particular pack in Muckamore in my experience there. You know there was -- just to add to Brona's; I am aware that the BSO carried financial audits of policies and procedures. You know, I am not sure of the frequency, but there 11:12

were certainly audits carried out.

81 Q. DR. MAXWELL: This is the internal function?

A. MS. HEANEY: Yes, the BSO... and I think RQIA also monitored the implementation of Article 116 for patients' property, and that was a learning point for the Trust in my time there, because large sums had accumulated for some long-stay patients, because it related to patients who were there for so long and large amounts of money. And the knowledge that Trust, key workers, not ward staff, key workers were required to put in place, for example, funeral plans or investment opportunities over a certain amount of money. And there was certainly an issue that once it got over a certain amount, I think it was about £20,000, they were required to refer that individual's finances to the master of the office of care and protection. 11:13 11:13 11:13

And there was some change in practice where the office of care and protection were no longer receiving that information and there needed to be a new process put in place. But I do know that a lot of work went into rectifying that and the social workers. I mean a lot of the social workers were from other trusts needed to put in place financial plans along with families and the patient for large sums of money so that we would be compliant with Article 116 of the Mental Health Order. And I understand RQIA inspected around the standards for Article 116. 11:14 11:14

82 Q. MS. KILEY: And they inspected Muckamore Abbey Hospital, in particular around that standard?
A. Yes.
83 Q. So if they had comment or improvement on those areas we would be able to see that in the various reports for the hospital? 11:14
A. Yes, there was a lot of work done. I know that was one of the failings or one of the service improvement areas for the hospital at that time.
84 Q. Thank you. 11:14
85 Q. DR. MAXWELL: Can I just go back to this cash in the drawer?
A. MS. SHAW: Yes.
86 Q. DR. MAXWELL: Who could access that? Would that only be the ward sister, or could the healthcare assistants go to the drawer and take the money out to buy things for patients? 11:15
A. No, the key for that would have been maintained with the bundle of keys for the ward, so it would have been the nurse in charge. 11:15
87 Q. DR. MAXWELL: The nurse in charge?
A. Yeah.
88 Q. DR. MAXWELL: And was there any review of how the money was being spent?
A. Yeah, I mean, there is -- there is reference to financial fluctuations reports. So they are done -- the ward sister audits the patient finance monthly, so there is a review carried out at that level once a month of the spend, you know, for the patient. 11:15

89 Q. DR. MAXWELL: So I am thinking, we did hear evidence from one family about a relative who had not been a smoker before admission to Muckamore and had started smoking, which meant that the staff had been accessing the cash for the cigarettes. Are the things in which it is being spent on being considered or just the balance? 11:16

A. No, if you look at the template that sets out, there is a year, an annual meeting with the patient and the social worker and financial officer, and that would be also then the family members, and they discuss things like that what the patient -- 11:16

90 Q. DR. MAXWELL: So that's since 2021?

A. Yeah.

91 Q. DR. MAXWELL: I am talking about prior to that? 11:16

A. No, I can't speak to before that, because that pre-dates my time in Belfast Trust, but I know that that mechanism is there now.

92 Q. DR. MAXWELL: So we don't know how that cash that's kept on the ward, petty cash we might call it, what it is being spent on, that's not being monitored as far as we know? 11:16

A. Well, it has been explained to me that it was for the patient's use if they wanted to go to the tuck shop or go out, there is a cafe on site that they can go out and get their lunch and things like that, that they would be able to avail of that. 11:16

93 Q. DR. MAXWELL: But to your knowledge it hasn't been formally monitored?

A. No.

94 Q. MS. KILEY: Thank you, Chair. Those are all the questions that I have on that topic, and it may be an appropriate time for a break, I am about to move to the topic of resettlement policies. 11:17

CHAIRPERSON: Yes. Just on that topic before we leave it, you've told us about the drawer, the new policy, et cetera, et cetera, but what about other patient property, like expensive shoes or things like that, would any record be kept of the clothes and things that 11:17 a patient brought in with them, where would that record be kept?

A. Yes, so on admission all items that a patient brings in, regardless of where they are in the Trust, are recorded. Anything valuable or of high cost would be 11:17 sent home and the families would be encouraged to take anything of high value away. Anything of high value or sentimental value that they wanted to -- that the patient wanted to keep, it would go to the cash office for safe keeping. Where a patient has capacity and 11:18 wishes to keep it, then it would be explained to them the risk of that.

CHAIRPERSON: Yeah, that's on admission, I get that. But say a carer or a parent brings in an expensive pair of trainers -- 11:18

A. Yeah.

CHAIRPERSON: Would those be recorded anywhere, or was there any policy? We are speaking of policy, was there any policy about recording that sort of expensive item

of clothing?

A. Not that I would be -- not for things like trainers and clothes. Everything is marked with the patient's name and the ward and things like that, but not -- there may be a conversation about the value of items with families but... 11:18

CHAIRPERSON: There is no formal structure to how that works?

A. No, and that would be the named nurse who would have that relationship with the family and have that conversation if it was to happen. 11:19

CHAIRPERSON: Okay. All right, shall we take a 15 minute break? Thank you very much indeed. Okay, we'll try and stick to 15 minutes. Thank you very much.

11:19

THE HEARING ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

95 Q. MS. KILEY: Now, Ms. Heaney and Ms. Shaw, I want to turn to our next topic, which is topic H in Module 3, resettlement policies and the provisions of monitoring for resettlement. 11:41

Ms. Heaney, I am primarily going to direct my questions on this topic to you. So the Trust deal with this in Chris Hagan's first statement, from paragraphs 192 to 207. And Mr. Hagan sets out and refers to the regional policy aims of resettlement since the late 1970s, and provides a number of regional policies in that regard. 11:42

Now, the Panel has those and indeed has heard about them from different witnesses so I am not going to ask you about those in detail, but if you can look with me please at paragraph 198 of Mr. Hagan's statement. That's at page 93 for the screen please. You can see there that Mr. Hagan refers to the relevant processes, you have that, Ms. Heaney?

A. MS. HEANEY: Yes.

96 Q. And you see he refers to the relevant processes that were applied by the Belfast Trust in respect of resettlement of patients at Muckamore Abbey Hospital. And I will just read what he says there. So paragraph 198 he says: 11:42 11:43

"The relevant processes for and model of resettlement, which applied in the case of individual patients at MAH, was reviewed and refined at various times during the primary time period being considered by the MAH Inquiry. 11:43

"In broad terms, it was an assessment led process which involved professional input from across the multidisciplinary team, such as medical, nursing, occupational therapy, positive behavioural support, speech and language therapy, across a number of different phases, assessment, planning review and trial. 11:43

"By way of recent illustration only this is reflected

in the following documents, copies of which are provided."

And he then sets out three documents. And I want to have a look at those with you, Ms. Heaney, because I have some questions about those. So if we could turn to the first one, which is referenced at paragraph 198A, described there as "a resettlement process document". That appears at page 015025. That should be on the screen in front of you now, Ms. Heaney. 11:43 11:44

So, you can see that this is a rather basic looking document, it is entitled "resettlement process". And it and appears to be a list of, perhaps a check list of sorts. You will see there is reference to initial nursing and medical assessments, initial MDT meeting, to discuss environment and staffing levels, search for available accommodation, liaison with providers, Housing Executive application, if required. And you can see on down the kind of check list of sorts, I won't read it through, but this document does appear to be informal in style, it doesn't have, for example, the Belfast Trust policy headings that we have seen on other documents. Are you familiar with this document? 11:44 11:44

A. No, I have not seen that document until recently. But what I can say in my experience of working closely with Muckamore between 2017 and 2019, is that it was -- I needed to examine the processes and, you know, from admission to discharge. It wasn't coming in fresh, you 11:45

know, as a new individual trying to get a sense of the admission, the treatment, the assessment and treatment processes and the discharge arrangements, you know, it took some -- they weren't immediately obvious. For example, I was unable to source a recent admission criteria, I wanted to know as a new director what are the admission criteria, how is that process managed? What is the immediate actions post admission. What does assessment and treatment look like? What does the discharge planning look like? 11:45 11:46

So in my experience I had to go through a process of discovery to try and refresh these processes. Obviously staff who worked within the hospital and in the community who were in reaching, you know, seemed to have a process in their heads, you know, or there was custom and practice. So certainly -- 11:46

97 Q. Are you saying then, Ms. Heaney, that it was a process that was in staff's heads in custom and practice, but it wasn't written down before, in the time whenever you -- 11:46

A. I could not find any document that contained all of this.

98 Q. And that was 2017?

A. That was 2017/'18. And I mean part of the work that we did at that time, as I mentioned earlier, we collaborated with other learning disability services to look at their assessment processes, and that's when we started to refresh those policies. We wanted -- myself 11:46

and the senior clinical team wanted to refresh all of the admission criteria and the assessment and treatment processes. I can only talk about the refreshment as opposed to what was there before. So we felt it was unsatisfactory and -- 11:47

99 Q. In what ways was it unsatisfactory?

A. Well, for example, there was no clear admission criteria, or at least that I as a lay non-medical person could understand. Reference was made to the Mental Health Order and, you know, the existence of a 11:47 Mental Health Order and a co-existing condition of psychiatric illness plus other, I can't remember there were about three or four criteria.

After visiting London I realised that there was a lot 11:48 of admissions to this hospital. I was advised by other consultant psychiatrists that most of the admissions could have been prevented if there had have been the appropriate processes preadmission.

11:48

So the putting in place, for example, or, you know, the clinical director at the time put in place preadmission meetings. We borrow the term Blue Light meetings from the English guidance on care and review, which meant that any -- and also when I looked at the admission 11:48 patterns they tended to be after hours, at weekends, which suggested -- well, suggested that maybe crisis were developing during the day and then, you know, at night when there was less systems and processes in

place. So we modified that and put in place Blue Light meetings, which really was an attempt to sit down with the referring agent, whether it was our own community teams, quite a lot of them, or the other trusts, what's the problem? What can we do about it? Can we put in behaviour support services? If it was an appropriate admission in terms of meeting, Dr. Dougherty and her colleagues developed clear criteria, she had work shops with other trust colleagues to try and agree this criteria, and then we implemented them. 11:49

CHAIRPERSON: And when was this?

A. This was 2018.

CHAIRPERSON: And presumably when you conducted that exercise you reviewed what paperwork there was available? 11:49

A. Dr. Dougherty and her team would have, she developed new documentation, upgraded documentation.

100 Q. MS. KILEY: And I think in fairness we heard from Dr. Dougherty yesterday. And Dr. Dougherty has provided some further documentation, I think the admissions document may be one of those, so the Inquiry will look at that in due course and may hear from Dr. Dougherty about that. 11:49

A. Okay. So in a nutshell, we tried to refresh the admissions, the processes within the wards, so we implemented daily safety, things like daily safety briefs and weekly governance meetings just to refresh them and bring all the staff on board with that. And things like PIPA meetings, which were very successful 11:50

in the mental health wards in other hospitals --

CHAIRPERSON: Can you just help me with PIPA?

A. It really was a daily ward round where, you know, all of the team got together and really looked, focused, other distractions were removed, and there was a focused multidisciplinary look at why is this patient here? What's the current medical plan? What's the discharge plan? So it was like a focused action. And then tasks would have been distributed to various members of the multidisciplinary team in the ward rounds. 11:50 11:50

And as part of that process we also looked at the discharge, because I had issues, or the families had raised with me that the ward rounds were too long, they were meandering, they were -- you know they didn't get to the point in terms of when the admission -- when the discharge was going to happen, or where were they with the placement or the new housing option. 11:51

So we did a review of the processes and refreshed them. And we put in additional resources in the discharge part of the patient journey. I mean obviously that didn't help with the supply of the right types of accommodation and support. There was another piece of work that was required to refresh that, because when I was in the -- in my period of time there were no regional structures to tap into in terms of developing new housing and support options, that I think has moved 11:51 11:51

on since then, but at that particular time.

So, I'm not sure if that is addressing the question, but I would suspect that's a check list that somebody has, you know, developed just as a mental, you know, just as an aide-memoire. 11:52

101 Q. MS. KILEY: But is it right to say that whenever you came into post in 2017, there was not a single collated policy document that set out the resettlement process?

A. Not that I could find. 11:52

102 Q. And you referred there to a review which you undertook of the discharge processes, when did that take place?

A. Well, that was an internal -- I appointed a colleague to do some -- I think it's maybe in this, it was really just a review of what happened when a patient was ready for discharge? How were they discharged from assessment and treatment? And what happened after that? You know, in terms of -- the PIPA meeting was very much around a daily look about the assessment and treatment and any discharge planning. And then there were discharge planning meetings that included community staff. 11:52 11:53

And these conversations -- there was a very, very intensive process I learned in terms of the assessment required of essential lifestyle plan, which needed to involve the families as the experts in their individual, there were gaps in some of these, so we were trying to refresh those processes to ensure that 11:53

families were fully engaged and that their options and choices could be made more explicit, and that the communication was improved.

Now, there were gaps in the resources to achieve a lot of this, but at that point when I was undertaking this exercise it was discovery, it was really trying to diagnose what are the blocks here and what do we need to do to help the process. 11:53

103 Q. There is a document, Ms. Heaney, in the papers, and I want to check if this is the one you are referring to, can we bring up page 015104 please. 11:54

It may or may not be the document you are referring to, so please tell me if it's not. This is a document that was prepared in June, it's 015104 please, summary of learning from unsuccessful trial placements. Is that the document that you are referring to? 11:54

A. Yes. Well, that was part of it, there was another document just around barriers to successful discharge that the same individual undertook. And that was really, just as I mentioned, a discovery to try and figure out where were the blocks within the Belfast Trust and were there things that could be done within my remit that could unblock them. So it was the learning from that that helped us change some processes and put more resources into... 11:54 11:55

104 Q. And was that the purpose of the review to understand more about what was happening?

A. Yes, yes.

105 Q. And to change what you could?

A. Yes.

106 Q. We can have a look through that document in fact, we can scroll down a little bit please. You can see it is authored by Fiona Rowan. And if we scroll down to page 015106. Thank you. Yes, you can see an introduction there, there is a background on review of SEAs 2019 to 2020. And we can see it is said there: 11:55

"During the period February '19 to February '20, there were a total of 25 patients with planned resettlements. Of the 25, 19 were successfully placed with six placements that were unsuccessful, three Belfast Trust and three Northern Trust. Each unsuccessful placement was followed by a review using the format of either a shared learning event or a significant event audit. The type of learning event was dependent upon the Trusts involved. All resettlements were patients from Muckamore Abbey Hospital." 11:55 11:56 11:56

There is reference there to -- there is clearly an analysis of resettlements or planned resettlements over the specified period. And it is clear that they were analysed using the format of a shared learning event or significant event audit. Is that sort of analysis something that only took place as part of this review process? 11:56

A. Yes.

107 Q. So it wasn't standard for the Trust to analyse field resettlements in that way?

A. Not that I am aware of. We introduced this because a readmission was such a traumatic experience for the individual and families that it really was, that it really needed to be properly understood, particularly when the patient had already been in the hospital for such an extended period of time. What had not -- why did it go wrong after all the time spent planning for the discharge, so that was the reason for it. 11:57

108 Q. And was this the first time that the analysis took place, June 2020?

A. There had been -- we formalised it through SEA, through the significant event audit at that time, but we already had been having more informal meetings about -- you know if the patient reappeared after being in the hospital for a long time and was readmitted over a weekend for some reason, you know, we would have had a de-brief, or the staff would have had a de-brief. And then it became more formalised into the SEA when Ms. Rowan was doing this research. 11:57

109 Q. When did that informal sort of analysis start?

A. 2018.

110 Q. So before the 2018 period, was there any sort of analysis or de-brief on failed resettlements? 11:58

A. I don't think there was any separate process, I would imagine, and I am only guessing here that they would have been discussed at multidisciplinary ward rounds, you know, the reasons, but to have a separate event to

do a more clinical analysis of why this went wrong and what is the impact on this individual of having come back into hospital after, you know, such a long time. You know, why did the placement break down so quickly? So that was really the reason for it. And we learnt a lot, it was a productive --

111 Q. In fact if we scroll down to page 15108, you can see some of the key learning and recommendations. So if you just scroll down there to Part 1 there please. You can see there a number of key learnings and recommendations, I won't go through them all, but for example, paragraph 1 there says: 11:58

"Significant areas have been missed in the assessment process, in particular the exploration of behaviours that have become well managed in the ward setting or by the MEAH environment, such is the impact of having easy access to open space, pod, sound proofing, et cetera. These can be difficult to recognise and understand how these translate into a new setting or replicate in the community placement settings involving psychology in the assessment process as being established to improve the assessment around identifying and managing behaviours". 11:59

A. Yes. 11:59

112 Q. There is reference there in that final sentence, Ms. Heaney, to involving psychology in the assessment process, and the phrase that's used is "being established". So is it the case that psychology only

became involved in the assessment process for resettlement in and around 2020?

A. Well, that certainly seems to suggest, but certainly in 2017/'18, we appointed a whole team of positive behaviour support nurses. So they would have been involved, I can't remember the specific detail, but perhaps in that case they also planned to involve clinical psychology as opposed to the learning disability PBS staff. That's what I think that refers to. You know, because if it's helpful, you know, I think the learning from that was, whilst the preparation had been extensive, particularly for patients who were maybe highly autistic, the shift itself was traumatic and the expertise maybe wasn't there in the community provider, in whatever setting. And following that process, some of the really talented nurses in Muckamore went with patients. You know, we tried that, we would do outreach, that was one of the actions we took after that so that, you know, to have the input of a familiar nurse from the hospital who was highly skilled and trained and knew the individual. 12:00 12:00 12:00 12:01

Obviously staffing constraints made that quite challenging at times, but that was one of the actions that arose after that. And that certainly was successful. And I would point out to the Inquiry that when we tracked the data, and we got data recently, the admissions fell dramatically after 2018 when we introduced the Blue Light meetings, and that may not be 12:01

the only factor, but it is certainly there to be seen. And the other factor was readmissions were a major issue, you know, there was a lot of readmissions from right across the three trusts, and they started to fall as well. 12:01

I mean as the system became more attuned to these more complex patients, I mean there had been a huge amount of discharges from Muckamore, you know, obviously there were stops and starts and challenges. But I think for 12:02 these last 50 or so patients, some who have been there for a long time, or some of the younger highly autistic young men, in particular, the process of leaving was also unsettling. But we learnt to stick with it for a while, support the provider, support the family, that 12:02 it may succeed.

CHAIRPERSON: When you said that some of your highly trained nurses went with the patient, do you mean just for an initial period to help settle them in?

A. Yes. 12:02

CHAIRPERSON: They obviously wouldn't stay at the...

A. No, no, I mean, and there was challenges around that too, because that integration is really needed between them. I mean the provider may have felt quite threatened or had been judged, so there was a bit of 12:02 work to be done there, but certainly it was very useful and resulted in successful placements. And I think then providers began then to see the merit of it and began looking at appointing positive behaviour support

staff and using the community teams to sustain placements rather than just a default to Muckamore.

CHAIRPERSON: Thank you.

113 Q. MS. KILEY: You referred, Ms. Heaney, to the difficulty with readmissions, and that being a significant issue. And we know that it was a wider regional objective to resettle patients from Muckamore Abbey Hospital for a very long time. And I am just wondering, since there was such -- resettlement was such an important regional policy objective, and since the failed resettlements resulting to readmissions were known to be an issue, why did the Trust not undertake the type of process that you instigated in June 2020 to look back and analyse the reasons for failed resettlements prior to 2020. Can you speak to that? 12:03 12:03 12:04

A. Well, I can't really. I mean, I'm quite sure they did in different ways, maybe not visible to me. But I mean in my experience and in conversations with staff at the time, you know, there were frustrations that patients, you know, were readmitted. And I think their general diagnosis was, you know, the gaps in community services for community assessment and treatment, access to mainstream mental health services and positive behaviour support and psychology, and that there was no option, but Muckamore being the default until those services were fully matured and in place. 12:04 12:04

114 Q. And one of the things that we see Mr. Hagan says that this document, the June 2020 summary of learning, fed into a 2021 document that set out the resettlement

process. So if we can just look at it, it is at page 15027.

And you can see it is entitled "resettlement process document MAH 2021". And if we just scroll down, the background to the changes, and it refers to the report summary of learning from unsuccessful trial placements there in the second paragraph. 12:05

If we scroll down to 15033 please, you see there is now a check list of the phases of resettlement. And there are various phases there. 12:05

There is another check list at page 15050, if we could just look at that briefly, that's the pre-trial on leave check list. And you can see the various entries there. 12:06

Is this the sort of document that was the purpose of the review that you conducted, this sort of standardisation of the resettlement process? 12:06

A. Yes, absolutely. I mean I haven't seen this particular one, but those sorts of check lists, very simple check lists are an excellent prompt for the team to satisfy themselves that everything that needs to be done has been done. 12:06

115 Q. And were they lacking whenever you came into post?

A. I wasn't aware of any such documents in relation to that. There could have been, I just wasn't aware of

them.

116 Q. So was it the case that whenever you came into post, resettlement was done on an ad hoc, or a patient by patient basis?

A. I don't think it was ad hoc, I just think there was an established process, perhaps not written down, but that you know, the hospital had their weekly multi-disciplinary meetings, discharge planning was part of that, community staff was invited, community staff went away and tried to find placements. They couldn't find placements, and so the cycle went on, you know, so it was almost like in a rut or a custom and practice process. So it was really just, you know, an opportunity. And it was really the clinical staff in Muckamore at the time who led these changes, and I supported them as the director, but the changes were led by the clinical team. 12:07 12:07 12:07

117 Q. The changes arising from the review that we have just looked at?

A. The in-hospital processes being refreshed. And I think because Dr. Dougherty was from mental health -- she was in consultant psychiatry in mental health prior to joining Muckamore, she had been through all that learning in the mental health wards. And it was, you know, a great opportunity to apply that learning in the learning disability hospital. 12:07 12:08

118 Q. I want to return to Mr. Hagan's statement please at page 93, paragraph 199. And he talks here, Ms. Heaney, about housing development, he says:

"You can see housing development was a critical aspect of planning for and the ability to implement resettlement. It was also a significant challenge to the progress of resettlement due to a shortage of appropriate accommodation and support services and misalignment between the separate health and funding streams."

Do you agree with that analysis, was that your experience, Ms. Heaney? 12:08

A. Well, yes, I mean, in a nutshell. I mean supported -- the Housing Executive and supporting people team were critical partners in the resettlement, and they had made an enormous contribution in my view over many years, because obviously the capital and the supporting people, revenue, and the skills, the technical skills in the design and procurement of supported living environments. And indeed we had a dedicated officer within the Trust at the time, Mr. O'Kane, who worked very closely with these, with the Housing Executive, and I attended many meetings with them in my previous job. So they were critical partners to deliver bespoke and procurement of ordinary social housing as well, and brought a huge amount of resource and expertise to the table. 12:09 12:09 12:09

I mean certainly for a period of time there was an overarching structure between the Board, the

Commissioning Board, and the Housing Executive and the Trusts, and indeed other partners that met very regularly; business cases were processed and rejected and modified, so there was a very robust structure there for a period of time, maybe from 2012 to 2015 that all the Trusts and the Board engaged in. And that did result in, you know, positive developments for new accommodation for resettlement.

119 Q. I am going to come on to ask you about supporting people, because Mr. Hagan refers to that too. But returning to paragraph 199, the other thing he says is: 12:10

"It is important to emphasise that the Belfast Trust's care management budget is extended only to the provision of care, it was not capital funding for the provision of homes and facilities." 12:11

So is that the reason why the Trust had to rely on and engage with other partners, for example, the Supporting People programme? 12:11

A. Well, yes, absolutely, I mean an individual's right to a home is not the responsibility of the Belfast Trust, who was delivering health and social care. I mean following Bamford, I understand, it was recognised that the Housing Executive and the Supporting People, revenue monies, would be prioritised for resettlement. 12:11

I mean Bamford set out that, I think was it 80 homes a year for 20 years. There was some attempt to quantify.

So obviously they were key partners and were critical to the success as far as it went and continued to be for the resettlement of people in long stay hospitals.

120 Q. You referred there to the prioritisation of funding for those schemes, but Mr. Hagan does in his statement refer to some challenges with the Supporting People programme. At paragraph 201 you can see those. He says: 12:12

"In the Autumn of 2016, the NIHE advised the Belfast Trust on housing support providers that the Supporting People budget was over committed and, therefore, announced a reduction in funding across all schemes. The consequence was that eight out of nine housing schemes intended for the resettlement of Belfast Trust patients were ended. This decision obviously had a detrimental impact on resettlement." 12:12 12:12

And he refers to a number of documents which I'll turn to. Were you familiar with that? 12:12

A. Yes.

121 Q. With that happening?

A. Yes.

122 Q. And can you describe the detrimental impact that it did have? 12:13

A. I mean it was devastating, you know, for the resettlement programme, you know, and we were -- you know we could understand the Housing Executive's rational up to a point, but it obviously paid to eight

of our schemes, at least temporarily. I mean the Supporting People, the Revenue Supporting People pays for the housing support as opposed to the care support, you know, there is an interface, but housing support is funding to help people maintain their tenancy and maintain maybe personal relationships, it is a different function than the care.

So there is always a bit of debate around the edges of the definitions. But the Housing Executive had capped that, you know didn't do incremental year on year increases. So ultimately the health boards care bit of the funding had to increase in order to maintain the service. So there was difficulties around, you know, the funding.

Most of us felt, well, that's social care funding, whether it is Supporting People or Trust community care monies. So that had an impact. And then obviously the cessation of capital developments was very concerning. And we -- Mr. O'Kane did a lot of work to try and -- I think he visited England and other schemes to try and find out how to leverage private capital monies, even just to explore that, because such was our concern that these schemes maybe wouldn't progress. And we did escalate it to -- Mr. O'Kane and others did escalate it to the Chief Executive at the time and --

123 Q. Which Chief Executive, the Trust's Chief Executive or the Housing Chief Executive?

A. It would have been to the Belfast Trust Chief Executive in 2016.

124 Q. And are you aware of any other type of engagement that the Belfast Trust had with the Supporting People programme and the Housing Executive to try and influence the decisions on budget and which schemes would be ended? 12:15

A. Yes, I mean the Planning and Contracts Team, there is a couple of staff there, Mr. O'Kane and other staff, and I as well attended a meeting, you know, to try and influence that. I mean they were very sympathetic and felt it may be, you know, a temporary thing, but they had a number of issues. They produced a paper, as I recall, setting out their rational and why they needed -- there was difficulties with the different variations in costs in different schemes that they needed to understand better. 12:15 12:15

CHAIRPERSON: Could I just ask, would that reduction in funding in 2016 have directly affected people who were just coming up potentially to be resettled out of Muckamore, or would it have affected a more long-term sort of... 12:16

A. It was more a long term. I mean I think if anybody was ready for resettlement the Board and the Trust found the money, you know, it was a priority. But over the long-term with no incremental increase in the Supporting People budget it inevitably would have increased the demand for social care budgets, and that was never fully, was not resolved in my time. 12:16

125 Q. MS. KILEY: You refer to the issue being escalated to the Chief Executive, Mr. Hagan does provide a copy of a presentation that was given to the Chief Executive at the time. It appears at page 015418.

12:16

Mr. Hagan describes this as a September 2016 Belfast Trust presentation to the Belfast Trust chief executive concerning the cessation of the supported living programme.

12:17

In fact I think it might commence on the page above, if we can just go up one page please. Yes, you can see that title there. If we scroll back down to page 015418. Yes, thank you. You can see there a summary of the "S Housing", presumably that's supported housing 12:17 tenancies at September 2016. Belfast four year housing plan. And you can see it is broken down into various services, and there is a learning disability entry. Number of schemes delivered: 11. Number of new tenancies delivered: 79. Planned tenancies at risk: 12:17 38.

So, does that mean as a result of the cuts to the supported living budget at this time there were 38 planned tenancies at risk in the learning disability 12:18 sector?

A. Yes.

126 Q. So can we scroll down to the next page please. Scroll down please to 15420, the next one. You can see there:

"The following planned supported housing schemes are now at risk and unlikely to proceed. Learning disability, four schemes, 38 tenancies."

When it says there 38 tenancies, Ms. Heaney, is that effectively 38 patients?

A. Yes.

127 Q. And are they all -- would they all have been patients from Muckamore Abbey Hospital? 12:18

A. Not necessary, because we also have a community demand for specialist housing, but a lot of them would have been from Muckamore.

128 Q. And are you aware of what the chief executive did with this information? 12:18

A. I am not, I wasn't at the meeting, so I am not sure what happened.

129 Q. Are you aware if the Belfast Trust had an opportunity to make representations to the Housing Executive about which schemes ought to be prioritised? 12:19

A. I know that Mr. O'Kane and others in the planning department had regular conversations, there was a very close relationship, and I am sure there would have been opportunities to maybe prioritise, and that would have been taken. 12:19

But at that particular time the Supporting People and capital programme for resettlement stopped and their attention went to the homelessness strategy, as said

there, so...

130 Q. And was the result of that that any patient from Muckamore Abbey Hospital who had a planned resettlement was then delayed in their discharge?

A. Yes. 12:19

131 Q. Did the Belfast Trust take any measures to try and mitigate the impact of a delayed discharge on a patient at Muckamore. So I am thinking, for example, if a patient is being prepared for discharge and prepared for resettlement and then meets the devastating news 12:20 that that's not going to be able to take place, what steps do the Belfast Trust, setting aside the strategic and lobbying the Housing Executive, for the patients in Muckamore Abbey Hospital, what steps did the Belfast Trust take to try and mitigate the impacts on their 12:20 daily lives?

A. Well, just for clarity, I mean, at that stage of planning individuals would not necessarily have been identified. So it is not that an individual in Muckamore would be told, well, you know, it's not 12:20 happening. These were very much in the preliminary stages, these were identification of sites, identification of design and the technical side of it. And the revenue cost from care and Supporting People perspective, this was the early stages. So individuals 12:20 would not have known.

What the Trust did and continued, I imagine continued to do, is to identify alternatives. So I know

Mr. O'Kane did a piece of work to try and leverage private capital, and I'm not sure what success he had, there was no regional guidance available on that. But we would have then gone back to our current providers in the voluntary and private sector to see what vacancies they had, what modifications they could do, perhaps to buildings they had, you know, to try and find alternatives. I mean we expected this would be a pause as opposed to a forever situation. 12:21

132 Q. And was that -- did that -- was it a pause? 12:21

A. I actually don't know.

133 Q. Okay. Are you aware if the Supporting People programme ever picked up again after this 2016 period? You refer to a diversion of interest to the homelessness?

A. Yes. 12:21

134 Q. Was that a forever decision in terms of Supporting People, or did Supporting People continue?

A. No, I mean, obviously, the Supporting People revenue funding continued, because we have such a range of schemes across Northern Ireland, and they all continued to be funded by Supporting People. It was the two issues of capital, new capital monies and uplifts to the revenue of Supporting People. Those were the two issues. And I'm not sure if they have been fully resolved to date, since my retirement, whether they have been. 12:22 12:22

135 Q. And we know that delayed discharge was historically an issue in Muckamore Abbey Hospital in any event. And just going back to my question about what the Trust did

about that, even if it is the case that an individual patient might not have known that there was a scheme for them and they were ready to go, if they are on delayed discharge that means that they have been assessed as being fit for discharge, isn't that right? 12:22

A. Yes.

136 Q. So one could imagine that a delayed discharge might then lead to frustration on behalf of the patient and perhaps lack of opportunity within an in-patient hospital setting. Given that delayed discharges were 12:23 an issue for Muckamore Abbey Hospital, did the Trust put in place any policy about how it would mitigate the impact of delayed discharge on individual patients?

A. Well, I can only relate to my experience; I mean the delayed discharge populations as well as the original, 12:23 what is referred to as the PTL patients, before 2007 --

137 Q. What does PTL mean?

A. Well, I think certain patients were characterised as the patient target list for resettlement going back to 2007, at an earlier policy. It meant that if people 12:23 were delayed for a year in 2007, a list was created of those individual patients, and it was referred to thereafter as the PTL list.

But clearly since 2007, when the new hospital wards 12:23 were implemented, I mean there was new wards put in place in 2004 -- between 2004 and 2006, I think, around that early 2000 period. I think it was anticipated at that point that the hospital would move towards an

assessment and treatment function and the PTL -- sorry, the PTL patients would be resettled.

But what happened was they were resettled, but in a much slower way, and a new delayed discharge population emerged, which is obviously of great concern for obvious reasons.

138 Q. And as a result of that my question is, did the Trust put in place any procedure or policies to particularly address to mitigating that challenge? 12:24

A. Well, there was a number of measures that we put in place in 2017/'18, one was as I've previously described to try and prevent unnecessary admissions and try and speed up the discharge, acknowledging the constraints were there. But also we put in place, the team put in 12:25 place a significant patient activity programme, every single patient had a bespoke activity programme, that the aim was to be tailored to their particular interests and, you know, what motivated them, but also to make sure they were off-site, off the wards as much 12:25 as possible.

And there was a whole range of programmes, agricultural programmes, physical activity, cycling, swimming was reemerged. We brought in additional staff and 12:25 different resources so that every patient, as far as possible, as their illness allowed, that they were not on the wards during the day, they were either out completely in the community doing activities or were

for the more complex or patients who experienced more challenges being out, the day care, the therapeutic day care setting which needed to be used much more fully. So those were the things we tried to do to mitigate --

139 Q. When was that initiative -- 12:26

A. 2018. I mean obviously the therapeutic day centre was always there, it was really just to build on that and increase the range of activities and to constantly monitor it.

140 Q. DR. MAXWELL: Was this the day centre on site? 12:26

A. Yes.

141 Q. MS. KILEY: I want to move on now, Ms. Heaney, to discuss the subtopic of the monitoring for resettlement. And Mr. Hagan deals with that at paragraph 22 onwards of his first statement. 12:26

Now, he provides at paragraph 203, a list of regional mechanisms that provided oversight of the resettlement process. The Panel has that, and indeed has heard about regional oversight of resettlement from other 12:27 witnesses from the Department and from the SPPG.

But I want to ask you about The Trust's specific local processes. Mr. Hagan deals with that at paragraph 205 of his statement. And he says, within -- I beg your 12:27 pardon, if we could bring that up please, 205, and that's page 97. It should be on your screen now, Ms. Heaney. And you can see that it is said there: "Within the Belfast Trust, the MAH resettlement

programme was reported on and reviewed by the Muckamore Resettlement Group and the MAH Resettlement and Oversight Group."

Are those groups that are familiar to you, Ms. Heaney? 12:27

A. Yes, I mean, there was -- always had been, as I understand it, a resettlement team that met monthly within the division to review progress and issues.

142 Q. And who did that team report to?

A. They would have been in -- they would have reported to 12:28 the co-director in learning disability.

143 Q. And is that team something separate to the group's that Mr. Hagan is referring to here?

A. No, I think that's the same group.

144 Q. Okay. 12:28

A. The resettlement group. The oversight group would have been the director's oversight group, which dealt with a number of issues, including resettlement.

145 Q. And are you aware of the makeup of that group? Like what disciplines, what level of Trust representative 12:28 would have been on them?

A. There was two levels of that, there was the collective leadership team which met weekly, and that would have been psychology, divisional nurse, divisional social worker, you know, it would have been the senior team in 12:29 the division that would have had oversight of resettlement.

146 Q. When did that group commence?

A. Well, that group was in place when I was appointed in

2017, so there was the collective leadership team emerging for learning disability. The co-director, the senior manager there, she also had a monthly, at least a monthly meeting with the other assistant directors from the other trusts, particularly the two trusts that had large number of patients, the South Eastern and the Northern Trust, so she would have held, you know, a large database with every patient with details, it was an action plan which was updated monthly. And they would have had meetings with housing providers and provider organisations. So that structure was in place to try and drive resettlement collectively between those three trusts. 12:29 12:29

147 Q. And was that looked at on an individual basis, so was it looking at the resettlement of an individual patient? 12:30

A. Yes.

148 Q. So those groups weren't taking the sort of analytical insight that you then developed in 2020, looking at the reasons, perhaps, for the challenges of resettlement? 12:30

A. No, that group was looking at individual patients, what their plans were, what the barriers were to moving those plans on for each individual patient.

149 Q. And finally then on the topic of resettlement; I just wanted to ask you generally, Mr. Hagan has provided a list of a number of policies on the topic of resettlement. And in the list of documents provided there doesn't appear to be any policy that touches on the interaction between the Belfast Trust and other 12:30

trusts in respect of the resettlement of patients from Muckamore to another Trust area. Is there such a policy?

A. Sorry, I don't quite understand that question.

150 Q. I am thinking about the process of a patient from Muckamore Abbey Hospital who has resettled to a different Trust area. And there must then have to be a relationship between the Belfast Trust, as the service provider for Muckamore, and the other Trust, is that right? But there doesn't appear to be a policy document that covers that relationship on resettlement. Does one exist? 12:31 12:31

A. Well, I would like to clarify that the assistant director grade of the three Trusts met weekly, there was very close relationships between those three assistant directors and indeed from the Western Trust and Southern Trust, there was a small number of patients maybe on the forensic ward, they met regularly. So there was strong relationships there. And, you know, every patient would have been discussed and plans maybe to, you know, support each other. So it was very much a collaborative model between the Trust at assistant director level to progress resettlements. And it was reasonably successful, given when you look at the number of discharges that occurred, and we have that data for the Inquiry if they wish to look at it. 12:31 12:31 12:32

I think what you are referring to is the care

management guidelines that say a Trust of origin if a Belfast Trust patient went to live in a different Trust area and they went into a residential care home, then there would be procedures, the care management procedures would apply. Which meant, in essence, that the Belfast Trust would continue to fund that patient and would continue to be responsible for care reviews.

151 Q. Yes, and you referred to that yesterday, was that a 2004 circular? 12:32

A. Yes, 2010.

152 Q. But that only applies to someone who is moving into a residential facility, isn't that right?

A. Yes.

153 Q. So that wouldn't apply to someone who is moving, for example, to supported living? 12:32

A. No.

154 Q. Okay. So there is nothing formal that governs that -- nothing formal in writing that governs that?

A. No, and I think there has been some confusion about it, but if somebody moves to an area, that area needs to take on the responsibility of their primary care, secondary care, you know, they are now a citizen in that other area. It's their home address. But on a practical level there would have been some level of follow through from the current clinical team for a period of time until that person was handed over to the new Trust of residence. 12:33 12:33

So how long that was and what protocols I am not clear

about, but I am aware that that did happen. Obviously there were work short vacancies, particularly in psychiatry that were problematic.

155 Q. DR. MAXWELL: We did talk about this yesterday, but I think the issue is that some patients are discharged from care. 12:33

A. Yes.

156 Q. DR. MAXWELL: If you have been in Muckamore, you are not a life-long responsibility of Muckamore. You are discharged from that care and you are then responsibility of primary care, wherever you live? 12:34

A. Yes, unless your needs change.

157 Q. DR. MAXWELL: Unless your needs change when you might be re-referred to psychiatry or LD. The relationship in care homes is because you are funding that care not because you are managing that care, is that right? 12:34

A. Yes, I mean, that certainly what the procedures set out, much with the rational, but the rational was at the time that the Trust of origin were responsible for the funding and the quality. 12:34

158 Q. DR. MAXWELL: But if you are not funding the care, Belfast Trust doesn't have any -- the patient discharged from Belfast Trust is not responsible?

A. Yes, that's correct.

159 Q. MS. KILEY: You referred to some confusion around this, was it your experience that there was confusion whenever a patient was resettled from the Belfast Trust to a different Trust area? 12:34

A. Well, perhaps that's not the right word. I think there

was just anxiety because perhaps for the transition period that the medical team or other staff, the care manager, would follow them up for a period of time for continuity of care, but at the same time, you know, they also had new demands. It was just workload balancing.

160 Q. DR. MAXWELL: Can I just clarify then; so I'm thinking about other types of patients who will get formally discharged from care, and that's documented somewhere, would that have happened with people who are discharged from Muckamore, would there be a point at which you could say, this patient has formally been discharged from secondary care? 12:35

A. My understanding is that, yes, but obviously they had this concept, which believe is from the Mental Health Order, of trial resettlement, or trial discharge, which I couldn't fully understand, because reading the Mental Health Order it seemed to apply to people who had a severe psychiatric condition and were gradually, you know, returned to the community. But it also applied in Muckamore, which extended the clinical team's involvement and the hospital's responsibility for long, long periods of time. 12:35

161 Q. MS. KILEY: Thank you, Ms. Heaney. Those are all the questions that I have for you on the resettlement topic. 12:36

I am going to move now to our final topic, which is 3M, Policies and Procedures For Further Training For Staff

and Continued Professional Development.

Ms. Shaw, I am going to direct my questions primarily to you on this topic. It is dealt with in Chris Hagan's first statement at paragraph 320. It commences at 320 and goes on to paragraph 345. 12:36

If we could bring up page 142 of Mr. Hagan's statement please. Now, Ms. Shaw, you will have seen that in fact Mr. Hagan does set out a considerable amount of detail on the Trust policies on mandatory training. And he explains the various CPD requirements set by the various professional bodies and regulators. 12:36

The Panel has all that information, I am not going to ask you anything, any more detail about it. But I do have a general question, you can see there at paragraph 323, that Mr. Hagan says that: 12:37

"The Belfast Trust endorses a culture of life-long learning, in which staff feel valued, motivated and engaged, and have the knowledge and skills required to provide safe, high quality, and effective care. This also ensures that the Belfast Trust complies with its obligations and ensures effective risk management. " 12:37

Now, that might read, as one might say, it is a rather aspirational statement, and I just wondered if you can assist the Panel with how the Belfast Trust does

endorse a culture of life-long learning in the way described there?

A. MS. SHAW: So for all staff working in the Belfast Trust, we are required to complete statutory and mandatory training across the lifespan of our employment, and there is a training matrix for that which outlines the key things that every staff member needs to do, depending if they are clinical or non-clinical. 12:38

As well as that then for professionals working in the Belfast Trust, all professionals will be bound by continuous professional development. So continual professional development is part of the requirements for most regulators. So in terms of nursing it would be one of the components for my ability to reenter the NMC register on a three yearly basis. And each Regulator will outline what those requirements look like. 12:38

So CPD, depending on how many hours you have to do, will -- can take many forms, so that can look like attendance at conference, participation in project work, reading articles, involvement in different quality improvement work and being able to evidence how that has, I suppose, added value to your role, what your learning has been and how you have been able to bring that back into the Trust. And everyone who attends training, the expectation would be, if I attend 12:39

training I will bring back my learning to my team and share that learning.

162 Q. And does the Trust have systems in place to monitor that, to know whether people are bringing back and sharing that learning? 12:39

A. It would be an expectation of a professional to do that, you know, so it would be -- for example, with my own team, you know, if I attend a conference as part of my leadership, it would be my responsibility to do that, but we don't have a set way of monitoring that. 12:40 I wouldn't be asked to provide any assurance that I am doing that --

CHAIRPERSON: I'm so sorry, I didn't mean to interrupt you.

A. You're okay. 12:40

CHAIRPERSON: But endorsing a culture of life-long learning can mean a number of things, it is not just requiring staff to undertake their CPD, it's providing them, for instance, with protected time in order to do so? 12:40

A. Yes, yes.

CHAIRPERSON: Now, does the Trust have a policy around that? Later on this year we are going to be hearing from staff, do you think they are going to be telling us that they were given protected time in order to 12:40 complete appropriate training?

A. So as part of the staff appraisal that occurs every year, staff will meet with their line manager and they will discuss their career development or their -- any

wishes that they would have to undertake training.

And if staff wish to avail of training that isn't provided within house, within the Trust, staff can complete a study application form. And that then is how the staff will either receive the finances to attend that training or the time to attend that training. It wouldn't be usual that you would get both, you would either get the time or the finances to do so. And that would be generally how it would happen. 12:41 12:41

163 Q. DR. MAXWELL: How much money is put into the staff pay budget to support people to have time off?

A. I haven't looked at that for today, but it is something I can come back to you on. 12:42

164 Q. DR. MAXWELL: Because in order to have protected time people -- you will need to cover that somehow, won't you?

A. The budget -- the finances will come out of each directorate's budget, so it will be the director who will be responsible for facilitating that. So if I want to attend something, it would come out of my director's budget as opposed to an overall organisational pot for training. 12:42

165 Q. DR. MAXWELL: In previous evidence you have talked about how you established the numbers you needed and you talked a number of times about the Telford formula -- 12:42

A. Yes.

166 Q. DR. MAXWELL: -- and that requires a percentage to be put in for education?
A. Yes, yes.
167 Q. DR. MAXWELL: Do you know what the current percentage is? 12:42
A. No, I don't know that.
DR. MAXWELL: Okay, thank you.
CHAIRPERSON: Thank you.
168 Q. MS. KILEY: Ms. Shaw, one of the things that the Inquiry has heard is that there was a lack of 12:43
specialist learning disability nurses in Muckamore Abbey Hospital. How does the Belfast Trust organisationally encourage or incentivize staff members to undertake further specialist training? You have described the process what would happen if they asked 12:43
to do it, but how does the Trust encourage that?
A. That would be a conversation that happens between the line manager and the staff member at the appraisal on a yearly basis. And it would be maybe if somebody had demonstrated an interest or a particular talent in that 12:43
field and that the Trust felt that this would be an area that they would excel in. The line manager would have that conversation and encourage the staff member to think about applying to and maybe undergoing that kind of training. 12:43
169 Q. But more corporately, so a Trust Board level, for example, with the knowledge that there is that lack of specialist training, does the Board more corporately not take any measures to try and encourage that sort of

uptake?

A. I would have to come back on that, I'm sorry.

MS. KILEY: Okay, Ms. Heaney and Ms. Shaw, those are all the questions I have for you on the topics that were allocated this morning. The Panel may have some questions. 12:44

CHAIRPERSON: No, again I think we have asked the questions as we have gone along. So can I again thank you both for returning, perhaps particularly Ms. Heaney, who I think has answered the majority of the questions this morning, you have been very helpful. Thank you. I think we don't have any witnesses this afternoon, but we do have two witnesses -- 12:44

MS. KILEY: Tomorrow morning at 10.00am, yes, there are two more -- 12:44

CHAIRPERSON: And also one at 2 o'clock.

MS. KILEY: Yes. And they are Trust witnesses on Module 3 tomorrow morning.

CHAIRPERSON: Thank you very much. Okay, we will rise until 10 o'clock tomorrow morning. Thank you very much indeed. 12:45

THE HEARING ADJOURNED TO THURSDAY, JUNE 8TH 2023 AT 10:00AM