Muckamore Abbey Hospital Inquiry

Module 2 – Health Care Structures and Governance

MODULE 2 WITNESS STATEMENT
ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST

I, June Champion, Associate of the HSC Leadership Centre and retired Co-Director for Risk and Governance in the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on behalf of the Belfast Trust in response to a request for evidence from the MAH Inquiry Panel dated 9 December 2022. Module 2, addressing health care structures and governance, is said to be intended to address 9 broad topics or themes set out in the MAH Inquiry correspondence of 9 December 2022.

2. This is my first witness statement to the MAH Inquiry.

3. It is not possible for any one person in the Belfast Trust to address the matters the MAH Inquiry has asked the Belfast Trust to address in Module 2. Accordingly, while I am the witness statement maker on behalf of the Belfast Trust for the purposes of the MAH Inquiry Module 2 hearings, I make this statement having had the assistance of the following individuals:

    a. Maureen Edwards, Executive Director of Finance;

b. Claire Cairns, Co-Director, Risk & Governance;

c. Jennifer Thompson, Co-Director of Performance & Planning;

d. Tracy Reid, Interim Executive Director of Social Work;

e. Rhoda McBride, Divisional Social Worker;

f. Bernie McQuillan Co-Director of Planning & Equality;

g. Alistair Campbell Director of Performance, Planning & Informatics;

h. Rhonda Scott, Assistant Service Manager at MAH;

i. Marie Heaney formerly Director of Adult Social & Primary Care Services (retired);

j. Paul Devine, Clinical Psychiatrist;

k. Joanna Dougherty, Clinical Psychiatrist;

l. Magda Keeling, Service Manager, Commissioned Services;

m. Fiona Rowan, Interim Divisional Social Work and Social Care Lead;

n. Catherine O'Callaghan Project Lead for Commissioned Services; and

o. Kim Murray, Governance Lead, Commissioned Services.

4. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "JC1". The MAH Inquiry request for evidence can be found in the exhibit bundle.

Qualifications and Position of the statement maker behalf of the Belfast Trust

5. I qualified in 1980 as a registered general nurse and remained on the Nursing and Midwifery Council (NMC) until my retirement in 2014.

6. I hold a BA (Hons) in Public Policy and Management, which I obtained in 1998, and a Masters in Claims and Risk Management (LLM) in Healthcare, which I obtained in 2006.

7. From 2007, when the Belfast Trust became operational, I held the position of Co-Director for Risk and Governance. I held this position until my retirement from the Belfast Trust in 2014. From 2014 I have been an Associate of the HSC Leadership Centre.

The Context of Health Care Structures and Governance and Assurance

8. The nature of the provision of health and social care means that the structures that facilitate the provision of that care are complex. So too are the systems of governance and assurance that are put in place to try to ensure the care is provided safely.

9. This complexity is reflected in the September 2011 Department of Health, Social Services and Public Safety[1] Framework Document. The Framework Document aims to describe the roles and functions of the various health and social care

[1] From 8 May 2016 the health department was renamed the Department of Health pursuant to the Departments Act (Northern Ireland) 2016 and the Departments (2016 Act) (Commencement) Order (Northern Ireland) 2016.

bodies, and the systems that govern their relationships with each other and the sponsor department (now the Department of Health). It runs to some 57 pages and can be found behind Tab 2 in the exhibit bundle.

10. A further example of this is the May 2021 introduction of the Department of Health "HSC Board Member Handbook". It is one of the pieces of work resulting from one of a number of HSC workstreams responding to the recommendations of the 2018 report of the Inquiry into Hyponatremia Related Deaths (IHRD). The handbook is described as a "*resource to support the delivery of safe and effective care*". It is an overview summary document to assist Trust Boards to scrutinise the safety and quality of services and to support Non-Executive Directors of Trust Boards in their important leadership role. The handbook is some 374 pages and can be found behind Tab 3 in the exhibit bundle.

11. The inevitable complexity of the health and social care system is certainly reflected in a health and social care organisation that is the size, and provides the range of services, of that of the Belfast Trust. It is worth repeating some of the contextual points in that regard already made to the MAH Inquiry on behalf of the Belfast Trust:

    a. The Belfast Trust is the largest integrated health and social care trust in the United Kingdom.

    b. It delivers a wide array of treatment and care to around 340,000 citizens of Belfast, as well as providing the majority of regional specialist services for Northern Ireland.

    c. It operates across a number of hospital sites (such as the Royal Victoria Hospital, the Belfast City Hospital, the Mater Hospital, Musgrave Park, the Royal Jubilee Maternity Hospital and the Royal Belfast Hospital for Sick Children).

d. It contains the major teaching and training hospitals in Northern Ireland.

e. It also provides and operates facilities at Knockbracken, Beechcroft, the Iveagh Centre and Muckamore Abbey Hospital.

f. The work of the Belfast Trust is not limited to the care and services it provides in hospitals. It also delivers a vast range of health and social care services across Belfast to support service users to live within their communities. Those social care services include the provision of elderly care home placements, domiciliary care to over 4,000 services users across Belfast, the provision and operation of 14 day-centres, 5 residential homes, 5 supported living facilities, together with the provision and operation of 11 children's homes (which includes responsibility for over 950 looked after children amongst other things).

g. The Belfast Trust has a workforce of almost 21,500 full and part-time staff and is the largest employer in Northern Ireland. By comparison, the largest private employer in Northern employs less than 11,000 people. The combined total staff of the entire Northern Ireland Civil Service, employed across all the government departments here, is 21,400 staff. The Belfast Trust has approximately twice as many employees as each of the other regional health trusts in Northern Ireland.

12. It is also the case that the governance and assurance mechanisms within a health trust are in an almost constant process of development. This is due to internal factors, including the proactive regular review of mechanisms, but also reactive internal responses to learning from the likes of incidents, litigation and inquiries. It is also due to external factors, such as the incorporation of legislative change or the introduction and assimilation of fresh departmental guidance or protocols.

Topic 1 – Budget for Learning Disability and mental health services

13. I should say at the outset that I am not an expert on the funding of health services. In order to be able to say that which I have set out below I have had the assistance of Maureen Edwards, Executive Director of Finance in the Belfast Trust. I am aware that in turn Ms Edwards has drawn on the experience of her team in the Finance Directorate. If there are any matters relating to finance that I do not adequately cover in this statement then I will be more than happy to take any issues away, engage further with Ms Edwards and her colleagues, and come back to the MAH Inquiry on those issues.

14. Health and Social Care funding, from 1 April 2022, is allocated to the various Trusts via the Strategic Planning and Performance Group ("the SPPG"), which now sits within the Department of Health. Between April 2009, following the introduction of the Health and Social Care (Reform) Act (Northern Ireland) 2009, and April 2022, the commissioning functions of the SPPG were carried out by the Health and Social Care Board ("the HSCB").

15. Each year, the HSCB, and now the SPPG, allocates specific funding to the Belfast Trust for various different forms of care provision. The funding granted is communicated through Budget Service Agreements, an example of which can be found behind Tab 4 in the exhibit bundle. Those various forms of types of funded care provision are set out below in order of approximate level of funding received:

    a. Acute

    b. Elderly

    c. Primary Care and Adult Community Care

    d. Learning Disability

e. Mental Health

f. Family and Childcare

g. Maternity

h. Physical and Sensory Disability

i. Health Promotion.

16. As can be seen from the above list, the funding allocations received by the Belfast Trust treats learning disability and mental health services separately. The funding of MAH has always been part of the budget allocation provided for Learning Disability/Intellectual Disability, I have therefore more specifically focused on the budget for Learning Disability in the course of this witness statement.

17. Northern Ireland has an integrated model of health and social care. This means that there is no distinct or separate budget for each of health care or social care. The provision of social care services, like the provision of health care services, is integrated throughout each of the different Programmes of Care listed above, and the same can be said of its budget. Equally, provision for children's services, institutional services, hospitals and community support are also integrated throughout the above Programmes of Care and do not receive any separate budgetary allocation from the Department of Health.

18. It is the Belfast Trust's understanding from the health finances special focus report of the Northern Ireland Fiscal Council[2], which can be found at Tab 5 in the exhibit bundle, that per capita health expenditure in Northern Ireland sits around 7% higher than in England. While the health spend may be higher in Northern Ireland

[2] Sustainability Report 2022: special focus- Health, Northern Ireland Fiscal Council

in percentage terms, the health needs of the population in Northern Ireland are also proportionately higher than the needs of the population in England. This may be due to many socioeconomic factors including legacy issues from the likes of the "The Troubles", and the higher persistent poverty levels in Northern Ireland than elsewhere in the United Kingdom. The more rural nature of Northern Ireland is also understood to make healthcare in Northern Ireland more costly as it demands a greater number of smaller sized services throughout the region.

19. Whilst there is available comparative data for health spending, the Belfast Trust is not aware of any comparative analysis, or data that would lend itself to comparative analysis, for social care spending. Social care is delivered through local authorities in England, and this may explain why there is not at present data available to allow an accurate comparison to be made.

A general outline of the funding allocations for the Belfast Trust

20. The budgets received by the five Health and Social Care Trusts (leaving out of account the Northern Ireland Ambulance Service Trust) are to allow those trusts to deliver primary, secondary and community health care.

21. Trusts receive two primary types of funding: revenue funding and capital funding.

22. Within revenue funding, there are two further types of funding. The first is recurrent funding. In the main, health trust budgets are built up on an incremental basis. Each year the Belfast Trust receives the previous year's recurrent budget baseline, uplifted for pay and price inflation, and amended to reflect any new investment, savings or service changes. The majority of the Belfast Trust's funding allocation is therefore recurrent.

23. On the basis of recurrent funding, the Belfast Trust is able to complete a financial plan. However, the indicative recurrent funding provided for financial planning is

not always sufficient to discharge the Belfast Trust's projected costs in which case the Belfast Trust's Financial Plan can indicate an opening deficit.

24. The second form of revenue funding is non-recurrent funding. In recent years the Belfast Trust and other Trusts have relied on non-recurrent monies, provided at the beginning of the financial year or more often during the year when additional one-off monies become available through investment slippage or Departmental Monitoring Rounds to address their anticipated deficits. Throughout the financial year, the Belfast Trust engages with the commissioners and updates the SPPG (formerly the HSCB) on emerging or unexpected pressures and asks the SPPG to provide further funding to cover the pressure or shortfall.

25. The Belfast Trust also receives capital funding. Each year the Belfast Trust receives a one-year capital allocation, which represents its capital resource level ("CRL"). The allocation comprises capital for specific major schemes, such as the acute mental health unit on the Belfast City Hospital Site. It also receives a general capital allocation to cover smaller capital requirements. This capital allocation is not allocated to a particular service area. A bid for capital funding could be placed by any directorate from within the Belfast Trust. The bids are then prioritised by the Belfast Trust's Capital Evaluation Team, and funding decisions made accordingly.

26. In recent years there has been an increasing gap between the level of recurrent funding provided, and the financial needs of the Belfast Trust. In addition, there was exceptional one-off spending associated with Covid-19. Since the financial year 2019/2020, the proportion of the annual funding of the Belfast Trust that has been non-recurrent funding has continued to grow.

27. While to date the allocation of non-recurrent funding to the Belfast Trust each year has been sufficient to enable it to break even, there is no budget certainty in respect of non-recurrent funding.

28. The Belfast Trust is bound by the rules associated with public finances. The Chief Executive is the Accountable Officer for the organisation. For example, where funding is allocated to a specific programme of care, the Belfast Trust can and will only use that funding for services within that programme of care. That is to say, for example, that if new funding was allocated to Learning Disability, that funding would only be used by the Belfast Trust for the provision of Learning Disability services.

29. When the Belfast Trust became operational in April 2007, its budget brought together the budgets of the six legacy trusts that amalgamated to form the Belfast Trust. The opening budget for the Belfast Trust comprised the legacy rolled forward budgets, amended for agreed new investments and required Reform of Public Administration savings.

30. Each year the Belfast Trust works with the SPPG (formerly the HSCB) to agree the Belfast Trust's annual budget. This is done prior to the beginning of the relevant financial year, where possible, with the expectation that the agreed budget will be sufficient to cover existing and emerging pressures for that year, as well as agreed service investments that are to take place.

31. Annual budget allocations in previous years have included income reductions in respect of savings targets that the Belfast Trust was required to achieve. By way of example, this was the case at the commencement of the Belfast Trust in 2007, arising from required Reform of Public Administration savings associated with the merging of the six legacy Trusts.

The Belfast Trust's Financial Responsibilities

32. Each Trust Board of a Health and Social Care Trust is responsible for planning and controlling the activities, costs and income of the Trust, to ensure that it remains financially viable at all times.

33. The Belfast Trust's financial roles and responsibilities are laid out in its "Standing Financial Instructions and Scheme of Delegation". Examples of this document, which is renewed periodically, can be found behind Tab 6 in the exhibit bundle. All health trusts in Northern Ireland have a statutory obligation to break even each year. This obligation was introduced by section 15(1) of the Health and Personal Social Services (Northern Ireland) Order 1991 which states that *"Every HSS trust will ensure that its revenue is not less than sufficient, taking one financial year with another, to meet out-going properly chargeable to revenue account"*. This is known as the "break even duty". This duty was expanded upon in the 29 June 2000 circular HSS (F) 25/2000 which was provided by the then Department of Health, Social Services & Public Safety to the legacy health and social services trusts. A copy of the circular can be found behind Tab 7 in the exhibit bundle. The duty on the present Health and Social Care Trusts remains the same.

34. The effect of the breakeven duty is that Health and Social Care Trusts are not permitted to spend in excess of their annual income in any year. Trusts are also required to remain within their annual capital resource level. Within the Belfast Trust, this is robustly monitored throughout the year and evidenced in the annual accounts through an income and expenditure account.

35. To meet its financial responsibilities, the Belfast Trust produces two key financial documents at system level each year. The first is the Financial Plan section of the Trust Delivery Plan, and the second is the annual accounts of the Belfast Trust. Examples can be found at Tab 8 in the exhibit bundle.

36. In respect of the Trust Delivery Plan, this is produced at the beginning of each financial year. It reflects recurrent and non-recurrent funding that has been allocated to the Belfast Trust as well as its opening Capital allocation.

37. Since the Belfast Trust's inception in 2007, the Belfast Trust has regularly commenced the financial year with an opening financial deficit, attributable, in the main, to a combination of unfunded cost pressures and unmet savings targets. This has been reflected in the Belfast Trust's financial plan each year, along with potential solutions, risks and assumptions. On the whole, financial planning deficits have been addressed throughout the financial year, largely through the provision of additional non-recurrent monies, in order to allow the Belfast Trust to comply with its statutory duty to breakeven.

38. The Financial Plan is then updated throughout the year to reflect any additional non-recurrent funding that is allocated to the Belfast Trust, or conversely, any emerging/new pressures. Within the context of Learning Disability, the most common emerging pressure will relate to resettlement costs. Often, at the beginning of the year, the cost of a resettlement plan will not be known and cannot be accurately predicted, as each resettlement plan is costed on an individual basis.

39. The second key financial document that is produced by the Belfast Trust is a comprehensive set of annual accounts which are produced at the end of the financial year. The accounts outline performance in both revenue and capital for the year and demonstrate financial breakeven and adherence with the CRL. The accounts are audited before being laid before Parliament.

Finance within the Belfast Trust

40. The Finance Directorate, one of the Corporate Directorates within the Belfast Trust, is responsible for the two main financial documents referred to above, and for the engagement with commissioners over finance in what is now SPPG.

41. At the beginning of each financial year each of the other Directorates within the Belfast Trust receives from the Finance Directorate a copy of the Financial Plan, as well as a Budget Pack. An example of a budget pack can be found behind Tab 9 in the exhibit bundle. A Directorate Budget Pack sets out the duties and responsibilities of the relevant Director and the other budget holders within the Directorate in relation to their budget. The principal duties are to keep within the spend budgets allocated to them to enable the Belfast Trust to meet its overall breakeven duty, and, where there are new cost pressures, to identify those cost pressures with a view to collaborating with the Directorate of Finance to resolving those pressures.

42. In line with the Belfast Trust's Financial Management Framework, an example of which can be found behind Tab 10 in the exhibit bundle, Directors are accountable to the Chief Executive for managing their budgets and ensuring their staff perform their budgetary control responsibilities. Each directorate has its own Directorate Accountant, who reports to the Co-Director of Finance, and who supports Directors and provides any advice required. Directorate accountants prepare a suite of summary reports on a monthly basis to assist the Directors. This includes a summary of the monthly financial performance, an overview of any areas of concern or key spend trends and an analysis of workforce budget and spend. Directors are required to discuss these reports at senior team meetings, sign off on the reports and oversee action plans to address budget variances.

43. Finance Reports are also given to budget holders at all levels on a monthly basis, whether at divisional level, care delivery unit level, or down to ward level. For example, a Ward Sister will receive a financial report every month which will show what her budget is, and her monthly and cumulative expenditure. The Service Manager will then meet the finance team monthly to discuss the report.

44. On a monthly basis the Director of Finance provides a financial update to Trust Board, and on a regular basis to the Executive Team and the Trust's Senior Leadership Group.

45. Financial monitoring reports are submitted to SPPG on a monthly basis, along with a high-level summary narrative of the overall position.

Financial matters affecting MAH

46. A finance theme relating to MAH that has been prevalent from the Belfast Trust became operational in 2007 has been the increasing per capita spend. The reality is that the fewer patients MAH has, as patients are re-settled, the higher the required spend per capita within MAH. This has meant that as time has gone on, and resettlements have been successful, the cost per patient within MAH has increased significantly because the costs of staffing and maintaining MAH do not decrease proportionately to each patient who is discharged.

47. This is not a recent issue but has been a theme throughout the existence of the Belfast Trust. For instance, in 2007, the then Western Health and Social Services Board (from 2009 the Boards formed the one HSCB) withdrew further funding for MAH on foot of bed closures at Muckamore. While they did so on the assumption that fixed costs could be eliminated from the point in time those beds were closed, such costs could not actually be eliminated for the reasons cited above. The then Department for Health and Social Services and Personal Safety therefore had to provide bridging finance to meet the £0.47m shortfall that this created.

48. While the problem is not recent, it has been compounded in recent years because the patients who remain at MAH are those with some of the most complex needs in the United Kingdom, and therefore also the most resource intensive. The effect is that the cost per remaining patient increases even further.

49. Regardless of these facts, the Belfast Trust has continually ensured that it has funded MAH to the best extent that it can. MAH capital investments alone have involved very significant sums. For example:

    a. In 2007/2008 there was a projected spend of £1.286m for development works at MAH;

    b. In 2008/2009, £2.878m was allocated to Muckamore design fees out of a total CRL allocation to the Belfast Trust of £13.475m, and a further £4.878m was designated to Muckamore Phase 4 from approved capital schemes;

    c. In 2009/2010, £1.880m was committed to MAH out of the Contractually Committed Capital Spend.

50. The above does not include the smaller capital allocation requests that are made as and when required through business case proposals, such as those which were used when CCTV was installed in MAH. An excel spreadsheet outlining a selection of the capital payments allocated to MAH can be found behind Tab 11 in the exhibit bundle.

51. The costs of resettlement, however, are in many cases much more expensive. The Belfast Trust has regarded resettlement as a significant priority. Consequently, it has taken steps to ensure funds are available to allow resettlement to take place. The SPPG has assisted through accepting resettlement costs as inescapable pressures, and providing non-recurrent funding to meet those pressures. This is notwithstanding that dealing with matters in this way creates a significant accounting risk for the Belfast Trust.

52. Resettlement has always been costly, but to resettle the remaining patients will be amongst the most expensive because some of the patients who have not yet been resettled are those with the most complex needs. The resettlement plans that the

Belfast Trust will therefore have to fund in future years are likely to be much more expensive that those they have funded previously. Some community care placements are projected to cost upwards of £1m per patient per year. By way of context, a potential placement of a current patient with a very high degree of complex needs is projected to be £250,000 per year in a hospital in England. The consequences of the significant cost disparity over the longer term will be obvious.

53. It is also perhaps relevant to note that the budget allocated to the Belfast Trust cannot be used to build the houses and facilities required for community placements. Such costs are funded separately through the Department for Communities (previously the Department for Social Development). Funding streams from the Department for Communities have been a great source of difficulty, particularly since the funding for supporting housing began to end.

Topic 2 – Department of Health; oversight of learning disability services

54. The Department of Health will be able to explain to the MAH Inquiry how it goes about overseeing the provision of learning disability services in Northern Ireland.

55. In this area, I would make the following observation on behalf of the Belfast Trust for the assistance of the MAH Inquiry. There are three strands to governance within the Belfast Trust. The third strand is external oversight. The Department is one of the sources of this external oversight.

56. In the main, there are three parts to the external oversight performed by the Department of Health. First, the Department sets the Priorities for Action and targets which the Belfast Trust must work towards. Second, the Department gives guidance and sets standards which the Belfast Trust must consider and aim to meet. Third, the Department also has a scrutinising role, holding the Belfast Trust accountable for its performance.

57. The Belfast Trust must report to the Department in a number of different ways. Some of these reporting mechanisms are routine, such as organised meetings like the accountability review meeting. Other mechanisms are not routine, but arise through reporting requirements arising from the triggering of a Serious Adverse Incident or an Early Alert.

Topic 3 – Public Health Agency; role in organisation and commissioning services at MAH and quality improvement

58. The Public Health Agency will be able to explain to the MAH Inquiry how it commissions services in the area of learnings disability and at MAH.

59. It may be, when the Belfast Trust has had an opportunity to consider how matters are described by the PHA, that there are some matters that it may assist the MAH Inquiry for the Belfast Trust to respond to.

Topic 4 – Health and Social Care Board/Strategic Planning and Performance Group

60. The Strategic Planning and Performance Group (formerly the health and Social Care Board) will be able to explain to the MAH Inquiry its involvement with learning disability and MAH.

61. It may be, when the Belfast Trust has had an opportunity to consider how matters are described by the SPPG, that there are some matters that it may assist the MAH Inquiry for the Belfast Trust to respond to.

Topic 5 – The Trusts and MAH; historical overview

62. Given that MAH has operated for over 70 years, there is unfortunately no one within the Belfast Trust who can comprehensively speak to or comprehensively provide a historical overview of the Trusts and MAH.

63. Further, given that MAH was established in 1949, there are unfortunately no longer any staff members within the Belfast Trust that cover a significant period MAH's history.

64. Therefore, by necessity, the information provided below is an outline which has been discerned from relevant documentation and legislation. It is hoped it will be helpful to the MAH Inquiry. If there are any matters arising out of what has been said below, the Belfast Trust will undertake to consider those matters further within the Belfast Trust and thereafter provide further information to the MAH Inquiry.

MAH under the Eastern Special Care Management Committee

65. Following the passing of the Mental Health Act (Northern Ireland) 1948, Muckamore Abbey Hospital was established in 1949.

66. At that time the then Northern Ireland Ministry of Health was the government department responsible for healthcare in Northern Ireland.

67. By section 20(1) of the Health Services Act (Northern Ireland) 1948, the Minister of Health and Local Government was required to constitute a body to be known as the Northern Ireland Hospitals Authority.

68. The Minister did so through the Health Services (Constitution of the Northern Ireland Hospitals Authority) Order (Northern Ireland) 1948.

69. The new Northern Ireland Hospitals Authority established three Special Care Management Committees that covered the geographical area of Northern Ireland.

70. One of the three Special Care Management committees was the Eastern Special Care Management Committee ("Eastern SCMC").

71. The Eastern SCMC had responsibility for, amongst other areas, the City of Belfast and County Antrim. Muckamore Abbey Hospital, which is located in County Antrim, and which was used largely by Belfast patients, sat under the Eastern SCMC.

MAH under the Eastern Health and Social Services Board

72. In 1972 a new administrative structure for the provision of health and social services in Northern Ireland was introduced through the Health and Personal Social Services (Northern Ireland) Order 1972.

73. Article 16 of the Health and Personal Social Services (Northern Ireland) Order 1972 gave a power to the then Ministry of Health and Social Services to create Health and Social Services Boards.

74. The Ministry used this power to create four Health and Social Services Boards ("HSSBs") through the Health and Personal Social Services (Establishment and Determination of Areas of Health and Social Services Boards) Order (Northern Ireland) 1972. The creation of four bodies, as opposed to the previous three, meant that the responsibility for Belfast and Antrim was no longer covered by the one body. Responsibility for services for the geographical area of Belfast was given to the Eastern HSSB, and responsibility for the geographical area of Antrim was given to the Northern HSSB.

75. Despite, the areas covered by each HSSB being defined in statute based on local government districts, it is understood that because two thirds of the patients in MAH in 1972 were from Belfast, it was decided that Muckamore Abbey Hospital would be treated as a Belfast hospital. While this position does not appear to have

been expressly reflected in statute at the time, the fact that MAH was under the responsibility of EHSSB was later recognised in Article 11 of the North and West Belfast Health and Social Services Trust (Establishment) Order (Northern Ireland) 1993, which effectively recognised the Eastern HSSB as having had responsibility for the management of MAH prior to 1993.

MAH under the North and West Belfast Health and Social Services Trust

76. In 1991, the Health and Personal Social Services (Northern Ireland) Order 1991 gave the then Department of Health and Social Services the power to establish Health and Social Services Trusts to assume responsibility for the ownership and management of hospitals or facilities which were previously managed by Health and Social Services Boards.

77. In 1993, this power was utilised to establish the North and West Belfast Health and Social Services Trust ("NWBHSST"). The new trust became operational on 1 September 1993 under the North and West Belfast Health and Social Services Trust (Establishment) Order (Northern Ireland) 1993.

78. Under Article 3(2)(a) of the North and West Belfast Health and Social Services Trust (Establishment) Order (Northern Ireland) 1993, one of the two functions that the NWBHSST was specifically given was "to own and manage hospital accommodation at Muckamore Abbey Hospital, 1 Abbey Road, Muckamore, Antrim BT41 4SH and associated premises".

The scope of the NWBHSST's functions expand

79. In 1993, the NWBHSST's functions were limited (as was the position for any of the other new trusts) to the ownership and management of hospitals and facilities. However, Article 3 of the Health and Personal Social Services (Northern Ireland) Order 1994, meant that from March 1994 HSS Trusts could exercise, on behalf of

Health and Social Services Boards, some additional prescribed functions in relation to certain operational areas.

80. The prescribed functions that could be delegated to trusts included some of the statutory functions placed on the Health and Social Services Boards which are likely to be of interest to the MAH Inquiry; those contained in the Children and Young Persons Act (Northern Ireland) 1968, the Health and Personal Social Services (Northern Ireland) Order 1972, the Chronically Sick and Disabled Persons (Northern Ireland) Act 1978, the Mental Health (Northern Ireland) Order 1986, the Disabled Persons (Northern Ireland) Act 1989 and The Children (Northern Ireland) Order 1995.

81. The North and West Belfast Health and Social Services Trust (Establishment)(Amendment) Order (Northern Ireland) 1994 gave the NWBHSST some prescribed additional functions to exercise on behalf of the Eastern HSSB in the local government district of Belfast. The NWBHSST began to exercise these functions from 1 April 1994.

MAH under the Belfast Health and Social Services Trust

82. The scope of functions which could be exercised by a Trust on behalf of a Health and Social Services Board were expanded further in 2001 through the Health and Personal Social Services Act (Northern Ireland) 2001. This Act amended the Health and Personal Social Services (Northern Ireland) Order 1991 to give the then Department of Health, Social Services and Public Safety broader powers in relation to the establishment of Trusts. Trusts could be established to provide goods and services for the purposes of health and personal social services, as well as exercising, on behalf of Health and Social Services Boards, any functions that were previously granted.

83. In 2006, the then Department of Health, Social Services and Public Safety invoked this power to create, amongst others, the Belfast Health and Social Services Trust (the Belfast Trust). The Belfast Trust became operational on 1 April 2007, by way of the Belfast Health and Social Services Trust (Establishment) Order (Northern Ireland) 2006 ("the 2006 Order"). Article 3 of the 2006 Order set out the functions of the Belfast Trust:

    a. to provide hospital accommodation and services at the Belfast City Hospital, 51 Lisburn Road, Belfast BT9 7AB and associated hospitals including the management of the teaching and research facilities associated with these hospitals and the related support services, Forster Green Hospital, 110 Saintfield Road, Belfast BT8 4HD, Knockbracken, Saintfield Road Belfast BT8 8BH, Mater Infirmorum Hospital, 45/51 Crumlin Road, Belfast BT14 6AB, Muckamore Abbey Hospital, 1 Abbey Road, Muckamore, Antrim BT41 4SH, Musgrave Park Hospital, 20 Stockman's Lane, Belfast BT9 7JB, and associated premises, Royal Group of Hospitals and Dental Hospital including the management of the teaching and research facilities associated with these hospitals and the related support services;

    b. to provide community based health and personal social services from the trust headquarters and associated premises; and

    c. to exercise, on behalf of Health and Social Services Boards, such relevant functions as are so exercisable by the trust by virtue of authorisations for the time being in operation under Article 3(1) of the Health and Social Services (Northern Ireland) Order 1994.

84. The operational area of the Belfast Health and Social Services Trust depended upon the relevant function it was required to perform, as set out in Article 4 of the 2006 Order, but it was generally confined to the local government districts of Belfast and Castlereagh, with the main exception being the operation of MAH.

85. The functions of the Belfast Trust were streamlined through the Health and Social Services Trusts (Establishment)(Amendment) Order (Northern Ireland) 2008, which amended the functions of all the Health and Social Services Trusts to be:

    a. to provide goods and services for the purposes of the health and personal social services; and

    b. to exercise on behalf of Health and Social Services Boards, such relevant functions as are so exercisable by the trust by virtue of authorisations for the time being in operation under Article 3(1) of the Health and Personal Social Services (Northern Ireland) Order 1994(**8**)."

The Belfast Health and Social Services Trust becomes the Belfast Health and Social Care Trust

86. In 2009, health and social care in Northern Ireland was restructured again under the Health and Social Care (Reform) Act (Northern Ireland) 2009.

87. This saw the dissolution of the previous Health and Social Services Boards (under article 1(1)(a)). They were replaced by a single Regional Health and Social Care Board (what became known as the HSCB).

88. All Health and Social Services trusts were renamed as "Health and Social Care trusts" or "HSC trusts" (under article 1(3)(a)) and their various functions (previously delegated to trusts from the four Health and Social Services Boards) were now exercisable on behalf of the Health and Social Care Board. However, in substance, the functions of the Belfast Trust remained the same.

89. Therefore, from 2009 the Belfast Health and Social Services Trust became the Belfast Health and Social Care Trust. This continues to be the formal title of the Belfast Trust today.

90. The Belfast Trust has continued to be operationally responsible for MAH. MAH is one of three learning disability hospitals that remain in Northern Ireland; the other two are Lakeview in Londonderry and Longstone in Armagh.

Topic 6 – Belfast Trust and MAH management and governance structure

91. As with other matters addressed in this witness statement, it is difficult for any one person within the Belfast Trust to satisfactorily address all the matters that are covered in what is set out below. In order to provide the below information to the MAH Inquiry I have had the assistance of the following people: Claire Cairns, Jennifer Thompson, Tracy Reid, Rhoda McBride, Rhonda Scott and Joanna Dougherty. If there are any matters arising out of what is said below, which are of particular interest to the MAH Inquiry, I will undertake to have those issues considered further within the Belfast Trust and thereafter provide an additional response to the MAH Inquiry.

92. Although this statement relates to the Belfast Trust and its governance structures, in order to understand the development of the governance structures within the Belfast Trust it is also necessary to understand the origins of corporate and clinical governance in health care. This background helps explain how the governance structures have developed within the Belfast Trust.

The Emergence of Governance: Clinical and Corporate

93. "Corporate governance" as a phrase emerged in 1992, when it was defined in the Cadbury Committee in its report "Financial Aspects of Corporate Governance". The Cadbury Report had been commissioned by the London Stock Exchange. The Cadbury Report, as it is generally known, defined corporate governance as the "system by which organisations are directed and controlled". A copy can be found behind Tab 12 in exhibit bundle. The main principle of corporate governance is

that every institution should be headed by an effective board, which is collectively responsible for the success of the organisation. Although corporate governance initiatives in the early 1990s were focused on the private sector, many of the underlying principles, conclusions and recommendations were recognised as also being relevant to the public sector and to healthcare.

National Implementation of Clinical Governance

94. It is understood that in the wake of medical scandals in England in the 1990s, the concept of "clinical governance" was introduced to the NHS in England. The adoption of the concept was heralded in the December 1997 White Paper "*The New NHS, Modern, Dependable*". Clinical governance aimed at improving the quality of clinical care at all levels of healthcare provision. This led to the often quoted definition of clinical governance that was set out in the 1998 article by Scally and Donaldson "*Clinical governance and the drive for quality improvement in the new NHS in England*", which was published in the British Medical Journal:

> "a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

95. The World Health Organisation divides clinical governance into four aspects:

a. Professional Performance (technical quality)
b. Resource Use (Efficiency)
c. Risk management (The risk of injury or illness associated with the service provided)
d. Patient satisfaction with the service provided.

Regional Implementation of Clinical Governance

96. The 1997 Government White Paper on a *'New NHS, Modern, Dependable'* did not migrate to Northern Ireland in the 1990s, and therefore, initially, neither did the concept of "clinical governance".

97. It is the case that aspects of corporate governance did have a place in the healthcare system in Northern Ireland, through the implementation of a common system of risk management across the Health and Personal Social Services, and the development of controls and assurance standards for financial and organisational aspects of governance. However, there had been little widespread and systematic consideration of "clinical governance". This changed in 2002 when the then Department of Health, Social Services and Public Safety published a consultation document entitled "*Best Practice- Best Care*". To the extent that there had been some progress in developing clinical and social care governance arrangements prior to that point, they had been developed locally and voluntarily.

98. "*Best Practice-Best Care*" defined clinical and social care governance as a framework within which the Health and Personal Social Services organisations were accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. The framework was positive and developmental, seeking to continually improve the quality of care. It was also corrective, being seen as a way of addressing concerns.

99. The plan to introduce and operationalise the proposals was announced in July 2002, focusing on three main areas:

    a. Arrangements for setting clear standards for services;

    b. Mechanisms for promoting local delivery of high quality health and social care services through clinical and social care governance arrangements,

reinforced with a statutory duty of quality. These arrangements were to be supported by programmes of continuous professional development and lifelong learning and strengthened by enhanced arrangements for professional regulation;

c. Effective systems for regulating services and monitoring the delivery of services.

100. In July 2002, the then Department of Health, Social Services and Public Safety ("DHSSPS") wrote to the Chief Executives of all the Health and Social Services Boards, Health and Social Services Trusts and other healthcare bodies setting out the new arrangements in more detail and enclosing for comment a draft Circular on clinical and social care governance.

101. On 13 January 2003, the DHSSPS wrote again to the Chief Executives of the Health and Social Services Boards and Health and Social Services Trusts, amongst other healthcare bodies, attaching a final version of the Circular, which had been revised to take account of some of the comments received from the Health and Personal Social Services bodies. A copy of the Circular can be found behind Tab 13 in the exhibit bundle.

102. The letter stated that the intended purpose of the guidance contained in the Circular was to enable the recipients to formally begin the process of developing and implementing clinical and social care governance arrangements within their organisations, with effect from the date of receipt of the Circular, being 13 January 2003. It also noted that the requirements set out in the Circular had been kept to a minimum at that stage, and that more detailed requirements would be developments in conjunction with the Health and Personal Social Services ("HPSS") bodies.

103. The Circular itself considered that there were four key steps which all HPSS organisations needed to take in their first year.

104. The first step was concerned with establishing leadership, accountability and working arrangements. Within the first step, the Circular provided that the Chief Executive of each HPSS organisation would be accountable to their board for the delivery of quality, treatment and care by the organisation in the same way as they were already responsible for financial and organisational matters. The Chief Executive was required under the Circular to designate a senior professional at board level to support them in the discharge of their role as Accountable Officer by 28 February 2003.

105. By 31 March 2003, all HPSS organisations were also required to designate a Committee, with an appointed chair. The chair was to be a non-executive director. The committee was to be responsible for the oversight of the clinical and social care governance of the organisation. The committee would be responsible for assuring the organisation's board that effective and regularly reviewed structures were in place to support the implementation and development of clinical and social care governance. The committee would be charged with ensuring:

a. That where problems were identified, appropriate remedial action was taken;

b. Local community and service user input into the development and maintenance of clinical and social care governance arrangements;

c. That effective mechanisms for engaging the views of users and staff were developed; and

d. That a report was provided to the board which included recommendations, and any remedial action taken or proposed if there was an internal failing.

106. The Circular also proposed that the Senior Professional would likely wish to assemble a multi-disciplinary team, with each member having responsibility for different aspects of the arrangements.

107. The second step was dependent on how advanced clinical and social care governance arrangements already were within the organisation. Either the organisation was to review their current arrangements and progress towards complying with the principles set out in the guidance; or carry out an initial baseline assessment of capacity and capability.

108. Organisations which had begun to develop their own systems for clinical and social care governance, were required to review their current clinical and social care governance arrangements in light of the guidance.

109. For those organisations which had not begun to develop a system of clinical and social care governance, implementation should have been started with a baseline assessment of the organisation's position.

110. The review/assessment was required to show the organisation what it was good at, and less good at, and the areas that required development. It included a requirement for a development plan that gave clear milestones. It had to be completed by 31 March 2003.

111. The third step was to formulate a development plan in the light of the review or assessment, securing agreement and support for the plan across the organisation.

112. On the basis of the above review, by 1 May 2003 organisations were expected to establish a plan for developing and maintaining clinical and social care governance arrangements to address gaps in current performance, develop

infrastructure, identify and respond to staff development and organisations developmental needs and resource implications.

113. Step four related to clarifying reporting arrangements for clinical and social care governance as part of the management of the organisation and to arrange for the preparation of an annual report on what had been achieved and what was planned for subsequent years.

114. By 30 November 2003, organisations were expected to include in their Annual Reports for 2002-2003 an up-date on progress on the development of clinical and social care governance arrangements. Further, that in future Annual Reports there had to be a specific section giving a full account of the clinical and social care governance activities of the organisation.

115. This was the beginning of a structured and harmonised process of clinical and social care governance across health and personal social services in Northern Ireland.

116. The duty of a health trust to put and keep in place arrangements for the purpose of improving the quality of health and personal social services that it provided was also placed in statute for the first time, by Article 34 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

The beginning of integrated governance nationally

117. In the early 2000s, governance was still seen by health services across the United Kingdom as somewhat distinct processes in each field. The NHS in England had been operating clinical, social care and other aspects of governance as separate strands which together formed part of the process of corporate governance. In May 2004, the concept of "integrated governance" was introduced

to the NHS in England for the first time. The NHS Confederation, through its paper on *"The development of Integrated Governance"* encouraged the NHS to move governance out of individual silos into a coherent and complementary set of challenges, requiring Boards to focus on strategic objectives.

118. Discussions which followed the paper produced by the NHS Confederation confirmed that "moving from governing in silos (e.g. clinical governance, information governance) to an integrated agenda is both an essential and practical way for Boards to meet their responsibilities."[3] . In 2006 the Department for Health of England and Wales produced a document entitled *"Integrated Governance: A handbook for executives and non-executives in health care organisations"*. It was to assist Trust Boards to achieve integrated governance. This handbook was the beginning of specific requirements of integrated governance being placed on Trust Boards in England and Wales.

119. This is when the concept of "assurance" became intertwined with the concept of governance. Previously, strategic planning and objective setting had not been performed in conjunction with, and alongside, risk assessments or monitoring by trust boards. However, the Department of Health for England and Wales considered in 2006 that "the key features to achieving integration" were straightforward:

- Aligning the organisation's strategic plan with the Assurance Framework;
- Testing each strategic objective against the high level governance framework;

[3] "Integrated Governance: A handbook for executives and non-executives in health care organisations" Department for Health of England and Wales

- Ensuring the Standards for Better Health and aligned to the organisational objectives, Assurance Framework and subsequent risks."[4]

120. Assurance thereafter became known as the mechanisms by which the Trusts can be assured that their responsibilities are being fulfilled, and Assurance Frameworks were the structure by which the Board ensured their responsibilities were being fulfilled.

Integrated Governance on a regional level

121. Despite the emergence of integrated governance in England and Wales, it was much slower to develop at a regional level in Northern Ireland. Clinical governance, as explained above, was only emerging from a departmental level in Northern Ireland from 2003. From March 2003, Trusts were required to use a Statement of Internal Control, a document relating to corporate governance but there was no requirement to indicate clinical governance arrangements.

Governance within the Belfast Trust

122. Governance at its most basic is the means by which an organisation ensures that it achieves its functions and aims and fulfils its responsibilities. The precise way in which the Belfast Trust has endeavoured to do this has varied over time. In view of the size of the Belfast Trust and given the multiplicity and complexity of the governance arrangements, it is not possible within the scope of this statement to give a clear and detailed account of every governance system and mechanism utilised by the Belfast Trust across a 20 year period. Therefore, below, for the assistance of the MAH Inquiry, I outline various governance themes within the Belfast Trust. Should the MAH Inquiry have a particular interest in a particular

[4] Ibid. Internal Page 21

system, mechanism or time frame, we will thereafter endeavour to give a more detailed account in that specific regard.

123. The first step in understanding governance is identifying the functions, aims and responsibilities that the organisation aims to achieve/fulfil.

124. At its most basic, the Belfast Trust was established for the purposes originally specified in Article 10(1) of the Health and Personal Social Services (Northern Ireland) Order 1991. When the Belfast Trust became operational in 2007 those purposes were:

> "(a) to provide goods and services for the purposes of the health and personal social services; or
>
> (b) to exercise, on behalf of Health and Social Services Boards, such functions as are so exercisable by virtue of authorisations for the time being in operation under Article 3(1) of the Health and Personal Social Services (Northern Ireland) Order 1994; or
>
> (c) to exercise, on behalf of Health and Social Services Boards, such functions as are so exercisable by virtue of authorisations for the time being in operation under Article 3(1) of the Health and Personal Social Services (Northern Ireland) Order 1994."

125. In 2009 small changes were made to these purposes by the Health and Social Care (Reform) Act (Northern Ireland) 2009, but otherwise these purposes were consistent through the duration of the primary date range of the MAH Inquiry's Terms of Reference ("primary date range"). More significant changes have been made since the end of the primary date range, which can be explained in more detail should that be of assistance to the MAH Inquiry.

126. The nature and functions of the Belfast Trust can be found in Article 3 of the Belfast Health and Social Services Trust (Establishment) Order 2006. Between 2006 and 2008, these functions could be summarised as follows:

a. To provide hospital accommodation and services at various hospitals throughout Belfast as well as at Muckamore Abbey Hospital;

b. To provide community based health and personal social services from the trust headquarters and associated premises; and

c. To exercise, on behalf of Health and Social Services Boards (as they were then), such relevant functions as were exercisable by the Trust by virtue of authorisations given by the Boards under Article 3(1) of the Health and Social Services (Northern Ireland) Order 1994.

127. In 2008, the functions of all the then Northern Ireland health trusts were streamlined through the Health and Social Services Trusts (Establishment)(Amendment) Order (Northern Ireland) 2008. This legislation amended the functions of all the health trusts to be:

a. to provide goods and services for the purposes of the health and personal social services; and

b. to exercise on behalf of Health and Social Services Boards, such relevant functions as are so exercisable by the trust by virtue of authorisations for the time being in operation under Article 3(1) of the Health and Personal Social Services (Northern Ireland) Order 1994(**8**)."

128. Other than minor linguistical changes, the functions remained the same throughout the remainder of the primary date range, although more significant changes were made in April 2022. The final element of Article 3 of the 2008 Order

encompasses many more functions which were exercisable by the Trust on behalf of the HSSB. Examples of those functions which may be of interest to the MAH Inquiry are the same as those listed above under the NWBHSST.

129. The Belfast Trust also has statutory responsibilities in addition to its functions. Two notable examples are given by way of illustration. Article 90 of the Health and Personal Social Services (Northern Ireland) Order 1972 required each Trust to keep proper accounts and records and to prepare a statement of accounts in respect of each financial year. Article 34 of the put in the name of the legislation 2003, as has already been mentioned, required the Belfast Trust to put and keep in place arrangements for the purpose of monitoring and improving health and personal social services (later amended to health and social care) which it provides, and the environment within which it provides them.

130. In addition to the statutory functions and purposes, the Belfast Trust also has organisational objectives which are set out in the Belfast Trust's Corporate Plan. The Corporate Plan outlines the vision (previously referred to as purpose), purpose (previously referred to as business), core values and key objectives/priorities that will shape the strategic direction and priorities of the Belfast Trust. The Corporate Plan is considered the managerial spine of the Belfast Trust. Examples of the Corporate Plan can be found behind Tab 14 in the exhibit bundle.

131. The Corporate Plan was previously renewed annually, but more recently the Corporate Plans have become longer term, spanning more than one year.

132. The vision of the Belfast Trust between 2007 and 2013 was "to improve health and wellbeing and reduce health inequalities". In the 2013-2014 Corporate Plan, there was a slight change to the vision of the Belfast Trust which added "…to reduce health and social inequalities". In 2018, the vision became "To be one of the safest, most effective and compassionate health and social care organisations".

133. The values of the Belfast Trust in 2007 were: respect and dignity; accountability; openness and trust; and learning and development. In 2013, these were reviewed and became: treating everyone with respect and dignity; displaying openness and trust; being leading edge and maximising learning and development. These were streamlined in the most recent 2021-2023 Corporate Plan to be: working together; excellence; openness and honesty; and compassion.

134. The objectives of the Belfast Trust, which were sometimes also referred to as "Corporate Themes", were originally "Quality and Safety", "Modernisation", "Partnerships", "Our People" and "Resources". The exact iterations of these objectives varied throughout the existence of the Belfast Trust, but the substance remained relatively consistent.

135. The Belfast Trust Delivery Plan is developed annually as a response to the Department's Priority for Action targets and previously, the relevant commissioning plans of Health and Social Services Boards as expressed in their annual Health and Wellbeing Improvement Plans. It describes at a lower level how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Belfast Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets. The Belfast Trust Delivery Plan also plays a crucial role in setting key performance indicators and the role they play in this regard is discussed further below.

Integrated Governance and the Assurance Framework within the Belfast Trust

136. Assurance in the wide sense is the means by which the Belfast Trust ensures that it fulfils the above functions, objectives and responsibilities. In 2007 there was a notable shift in the focus of assurance, instead of focusing on what systems were in place to manage governance, the focus became the mechanisms by which the

Belfast Trust would assure itself that the structures were working effectively. In trying to summarise all of the elements of governance and assurance, broadly speaking, the Trust Board can only properly assure itself that the structures are working effectively when it has in place:

a. An organisational structure capable of carrying out its functions while also creating adequate lines of accountability;

b. A full grasp of the principal risks facing the organisation and the potential attainment of its aims;

c. Adequate mechanisms to address the risks identified;

d. Adequate monitoring processes to ensure that the aims have been achieved or to reflect when they were not.

137. I do want to emphasise that the above groupings have only been created for ease and clarity in describing the different elements of governance and assurance in the course of this witness statement. They are not, in practice, distinct processes, nor are they mutually exclusive.

138. In considering assurance frameworks it is important to distinguish between an assurance framework as a concept and as the documents used to explain it. The concept of an assurance framework is the systems and frameworks discussed above when taken as a whole which ensure that there is quality assurance, accountability, risk management, continuous improvement and education within health care organisations. The Belfast Trust has used two documents, which are discussed below, to explain and illustrate the assurance framework that is in place.

139. The Belfast Trust, from its establishment, agreed an approach to governance and assurance which included the emerging guidance on integrated governance, as well as incorporating the relevant DHSSPS guidance at the time.

140. Similarly, the DHSSPS guidance in place at the time the Belfast Trust was established did not mandate each Trust to create an assurance framework, although the DHSSPS had issued guidance on "Establishing an Assurance Framework" in January 2006.

141. Despite there being no requirement to do so, the Belfast Trust maintained an assurance framework in line with the January 2006 guidance.

142. The terminology around assurance frameworks in health and social care in Northern Ireland has unfortunately been confusing. Steps have been taken and are being taken to remedy that through harmonisation of terminology across the Commissioners and all Arm's Length Bodies. The actual systems within the assurance framework have been reflected throughout the existence of the Belfast Trust in two key documents.

143. The first document has often been referred to within the Belfast Trust as a "Board Assurance Framework" which demonstrates that the Trust Board has been able to identify their objectives, manage the principal risks and achieve them, explains the links in the organisation's integrated governance and assurance chain and explains how the board continuously monitors the effectives of its internal control. Examples of the "Board Assurance Framework" can be found behind Tab 15 in the exhibit bundle.

144. The second document identifies the principal risks and is underpinned by the Belfast Trust's policy on risk and explains its approach to acceptable risk. The Belfast Trust initially referred to this document as the Principal Risk Document under 2020.

145. In order to harmonise the language being used in relation to these documents, in 2020, the Belfast Trust began to refer to the Principal Risk Document as the "Board Assurance Framework Risk Document". This aligned the language with that being used by the Department of Health. In 2022, to make a clearer distinction between the 'Board Assurance Framework' and the 'Assurance Framework', the Belfast Trust renamed the Board Assurance Framework, the 'Integrated Governance and Assurance Framework'. An example of the 'Integrated Governance and Assurance Framework' can be found behind Tab 16 in the exhibit bundle. While the names of the two documents have therefore varied, the substance has remained relatively consistent. Given that the Board Assurance Framework was renamed after the primary date range of the Terms of Reference of the MAH Inquiry, I will refer to it in the remaining course of the statement as the Board Assurance Framework.

Board Assurance Framework

146. The Board Assurance Framework provided a comprehensive and systematic approach to effective management of the risks to meeting the Belfast Trust's identified objectives and includes a wide range of assurances from both internal and external sources. It ensures that there are systems in place to monitor and review risks which are delegated. It sets out the organisational arrangements for governance and assurance as well as setting the definition of acceptable risk within the Belfast Trust's Risk Management Policy Statement, which is included as an annex to the Board Assurance Framework.

Belfast Trust Organisational Structures

147. The organisational structures adopted by the Belfast Trust have changed many times across the existence of the Belfast Trust. This is because the Belfast Trust continues to adapt and evolve based on the best information and knowledge

available to it at any given point in time. This is in line with its obligations to continuously improve the care that it provides, and endeavour to provide it in the safest way possible. This flexibility is also influenced by one of the quality standards for care which is that services must be flexible and tailored to the service being provided. However, in general terms, the Belfast Trust has always operated two parallel organisational structures: the Directorate structure and the Committee structure.

148. The structures encompassing Directorate areas has always been along the following lines:

i. A Trust Board;

ii. An Executive Team;

iii. Directorate areas (which were then made up of both operational areas and service areas).

149. In more recent years, since 2017, the Belfast Trust has also formally separated each Directorate areas down further into:

iv. Divisions

v. Care Delivery Units

150. Divisions and Care Delivery Units were formally adopted in 2017 through the introduction of the "Collective Leadership model". However, the concept of having smaller teams within a Directorate, grouped by their specialisms, was one which the Belfast Trust had adopted since it was established.

i. The Trust Board

151. The make-up of the Board of the Belfast Trust was originally determined by a combination of the Belfast Health and Social Services Trust (Establishment) Order 2006 (later amended by the Health and Social Services Trusts (Establishment) (Amendment) Order 2007) and the Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994 (later amended by the Health and Social Services Trusts (Membership and Procedure) (Amendment) Regulations (Northern Ireland) 1994).

152. Article 5 of the Belfast Health and Social Services Trust (Establishment) Order 2006 originally envisaged that the Belfast Trust would have, in addition to the Chairman, 5 executive directors and 5 non-executive directors. Due to the Belfast Trust having a significant teaching commitment, one of the non-executive directors was to be appointed from Queen's University Belfast. However, before the Belfast Trust became operational in April 2007, Article 5 of the Belfast Health and Social Services Trust (Establishment) Order 2006 was amended by Article 2 of the Health and Social Services Trusts (Establishment) (Amendment) Order 2007, so that the Belfast Trust required, in addition to the Chairman, 7 non-executive directors and 5 executive directors.

153. I have exhibited behind Tab 29 to this statement extracts from the Belfast Trust Annual Reports which show the membership of the Trust Board in any given year from 2007 onwards.

154. The Trust Board has always recognised that it is responsible for ensuring that it has effective governance systems in place, which are essential for the achievements of its organisational objectives. The exact permeations of these responsibilities have varied throughout the period under investigation by the MAH Inquiry. The Trust Board have always met frequently and presently do so on a monthly basis.

155. Within the Belfast Trust Board, there are five Executive Directors. The Executive Directors are determined by regulation 4 of the Health and Social Services Trusts (Membership and Procedure) Regulations (Northern Ireland) 1994 ("the 1994 Regulations"). In the Belfast Trust they are the Chief Executive, the Director of Finance, the Medical Director, the Director of Nursing and the Director of Social Work. The role of each the Executive Directors is set out in the Assurance Framework each year. In summary, they are governance roles with responsibility for maintaining the professional standards and all regulatory issues pertaining to their area.

156. Non-Executive Directors are appointed by the Department, as per regulation 3 of the 1994 Regulations. Non-Executive Directors have the role of assuring themselves and the Trust Board that the various Committees within the governance structure of the Belfast Trust (which are explained below) are satisfactorily addressing and managing key governance issues within the organisation. Their precise responsibilities include strategy, performance and risk. The Non-Executive Directors are responsible for ensuring the Board of the Belfast Trust acts in the best interests of the public and is fully accountable to the public for the services provided by the Belfast Trust. The precise position and role that each of the Non-Executive Directors hold is determined by the Scheme of Delegation and Standing Orders of the Belfast Trust.

ii. The Executive Team

157. The Executive Team of the Belfast Trust is comprised of the Executive Directors of the Board of the Belfast Trust, a Head of Communications and a number of Service Directors and Corporate Directors who are neither Executive nor non-Executive Directors sitting on Trust Board. The precise number and title of each of these Service and Operational Directors has changed over time in an effort to review and improve the organisational framework. These changes are reflected in

the extracts taken from the Trust Board Annual Reports, referred to above, and are also often referred to in the Corporate Plan.

iii. Directorates

158. When the Belfast Trust was established, it was structured around Service Delivery Groups, supported by a central core of Corporate Functions including Human Resources, Finance, Planning, IT, Information and Performance Management, Redevelopment and Estates, Risk and Governance, Corporate Nursing and Medicine.

159. This has since evolved to a structure based around Directorates, with each Directorate overseen by a Director who sits on the Executive Team. There are two types of Directorates: Corporate Directorates and Service Directorates. Any directorate which has a clinical or social care interface with a service user is a service directorate. These have also sometimes historically been referred to as Operational Directorates. The name and precise area covered by the Directorate has changed in line with changes made to the Directors who oversee them, as explained in the paragraph above.

160. The Belfast Trust has given some flexibility to Directorates as to the exact structure that each takes, to ensure that the structure of the individual Directorate is suitable to the services it manages and oversees. Service Directorates and Corporate Directorates often operate very different structures.

161. While there are differences between the precise structure adopted by each Directorate, the common features include that each Service Directorate has a Governance Manager, a Governance Group and also Risk Governance Staff with Directorate level oversight.

iv. Divisions

162. Directorates have always been broken down into smaller service areas. These more defined areas are now referred to as Divisions under the Collective Leadership Model introduced in 2017. They were previously referred to as operational areas. MAH, for example, sits within the division of Intellectual Disability Services.

163. Each Division in the Belfast Trust has a Collective Leadership Team or "CLT". The composition of the CLT in each Division varies slightly. The main variation is dependent on whether or not the Division is part of an operational Directorate or a service Directorate.

164. Within a service Directorate, the CLT is comprised of a Co-Director, Chair of the Division and Divisional Leads. The type and number of Divisional Leads may vary depending on the Division under consideration; they may include one or more of a Divisional Nurse, a Divisional Social Worker, a Divisional Psychologist and a Divisional Medical Lead. The type of Divisional Lead that is appointed to a Division is informed by the nature of the work performed. In the Intellectual Disability Services Division, which includes MAH, there is both a Divisional Nurse and a Divisional Social Worker on the CLT. The Chair has traditionally had a background in psychiatry.

165. A Co-Director is the operational manager for the service in each Division. The Chair of each Division is a medical professional.

166. The Divisional Leads also meet with the relevant Executive Director of their profession, as well as all the other Divisional Leads from across the Directorates from the same professional discipline, in order to look at staffing issues, Key Performance Indicators, to share information from their service and learning from

other services. They then provide professional advice and share their learning from other service areas with the Co-Director and Chair of their Division. For example, the Divisional Nurse from the Intellectual Disability Services Division would attend a monthly meeting with the Executive Director of Nursing, and all other Divisional Nurses, and then share their learning and advice with the respective Division's Co-Director and Chair of Division.

167. Other Professional Leads and Managers also have input at the Divisional Level. The Governance Manager for the Directorate will have input into each Division within their Directorate. Other Professional Leads in relevant areas such as Psychology or someone within the Allied Health Professionals will also have input at Divisional Level. For example, within the Intellectual Disability Services Division, there is a Lead Psychologist, Occupational Therapist and Carer Involvement and PPI Lead who work closely with those in the CLT for the Division.

168. This Divisional Structure ensures that staff have two lines of accountability, one to the person they report to on a daily basis in a managerial role, and a second professional line of accountability which can be traced through to the Director of their profession. This line of professional accountability is known as the "dotted line". The "dotted line" was first introduced in 2015 under the Belfast Trust's Organisational Development 2015-2025 framework document entitled *"Realising our ambition to be a world leader in the provision of health and social care"*. A copy of the document can be found behind Tab 17 in the exhibit bundle.

169. The structure within a Corporate Directorate can look quite different to a Service Directorate, and there is also variation within each of the directorates arising from the fact that the nature of the work performed can look very different. However, the premise is the same, a Director oversees other lead professionals who in some divisions may be a Co-Director, or a Chair and in others are entitled Deputy Directors.

v. Care Delivery Unit

170. Each operational division within a Service Directorate is broken down further into operational areas which are referred to as Care Delivery Units.

171. Care Delivery Units are led by Service Managers or Lead Nurses. Within MAH, they are referred to as a Service Manager. The Service Manager is intended to be a purely governance role. The Service Manager oversees Assistant Service Managers. They are also a governance role. Assistant Service Managers were previously referred to as Senior Nurse Managers. Within MAH, Assistant Service Managers have responsibility for the wards. There have typically been three Assistant Service Managers within Muckamore since the Belfast Trust was established and the various wards were divided between those three Assistant Service Managers.

172. Each Ward within MAH also has a Ward Sister, Deputy Ward Sisters, registrants (qualified nurses) and then non-registrants (care assistants).

Planning and setting targets through the Directorate Structure

173. The Corporate Objectives of the Belfast Trust and associated annual targets are cascaded throughout the Belfast Trust by:

a. Divisional Annual Management Plans;
b. Service/Team Annual Plans; and
c. Individual Objectives.

Examples of Management Plans relevant to Learning Disability can be found behind Tab 18 in the exhibit bundle.

174. Various other Plans are also produced by the Belfast Trust which are more specific to the service area or objective under consideration. Such plans include:

a. Capital Projects and Capital Planning Programme ;
b. Community, Elective & Unscheduled Care Plans;
c. Community Plans;
d. Disability Action Plan;
e. Equality Action Plan; and
f. Quality Improvement Plan/Quality Improvement Strategy.

Committee Structures

175. As I have said, parallel structures which exist alongside Directorates are the various Standing Committees of the Trust Board. The Committees themselves are broken down into sub-committees which are known within the Belfast Trust as steering groups. Below many of the steering groups are further advisory committees.

i. Standing Committees

176. While committees are part of the organisational structures within the Belfast Trust, they are heavily involved in risk identification and management and in auditing and performance management within the assurance framework. There are five Standing Committees in the Belfast Trust:

a. the Audit Committee,
b. the Assurance Committee,
c. the Remuneration Committee,
d. the Charitable Funds Advisory Committee, and
e. the Social Care Committee.

177. Each Committee is governed by a Terms of Reference which explains the positions of those who sit on each. Of particular interest under the topic of governance and assurance is the Audit Committee and the Assurance Committee. Each of these two Trust Board Standing Committees are comprised only of Non-Executive Directors of the Belfast Trust.

178. While the precise Terms of Reference may have changed over the years, in general the role of the Audit Committee is to assist the Trust Board in ensuring an effective control system is in operation. This includes the effectiveness of internal controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

179. Similarly, while the precise Terms of Reference may have been amended from time to time, the general role of the Assurance Committee is to assist the Trust Board in ensuring that an effective Assurance Framework is in operation for all aspects of the Belfast Trust's undertakings, other than finance. It therefore relates more closely to what would have traditionally been understood as clinical governance.

ii. Steering Groups

180. The sub-committees which sit underneath the Standing Committees are referred to within the Belfast Trust as Steering Groups. While these Steering Groups are within the Committee structures of the Trust Board and are, in structural terms, completely stand-alone from Directorates, there are Directorate representatives on each Steering Group at either Director or Co-Director level. Each Steering Group also has a Terms of Reference which outlines the members of the Group and their role.

iii. Advisory Groups/Teams

181. Each Steering Group is fed into by advisory groups which sit underneath them. There are a number of different advisory groups, each of which also has its own Terms of Reference, which support the work of the relevant steering group.

Risk Identification and Management

182. The nature and extent of the services provided by the Belfast Trust means that, as an organisation, the Belfast Trust carries and manages significant risk. Much time is spent endeavouring to identify the risks to patient safety and quality of care, as well as to the ability of the Belfast Trust to achieve its objectives. In line with the Assurance Framework, the Belfast Trust has always operated a Principal Risk Document, an example of which can be found behind Tab 20 in the exhibit bundle. As explained above, the name of the Principal Risk Register has varied over time. The Principal Risk Register is to assist in identifying any gaps in assurances, or potential risks to the attainment of the Belfast Trust's objectives is underpinned by the Belfast Trust's policy on risk and explains its approach to acceptable risk. The Principal Risk Register was later referred to as the 'the Assurance Framework' and in 2022 was renamed the 'Board Assurance Framework', in order to streamline the process with the labels given by the Department of Health.

183. The Principal Risk Document was underpinned by 3 levels of risk registers; a corporate risk register, a directorate risk register and a service level risk register. I understand that these are detailed more fully in the MAH Inquiry Belfast Trust Module 3 witness statement, but should the MAH Inquiry wish information on a particular aspect, the Belfast Trust can endeavour to provide further information.

184. The Belfast Trust endeavours to identify risk, and then manage the identified risk, in different ways. The assurances required by the Trust Board as to the

management of the identified risk are in turn proportionate to the level of risk identified. Some risks which may be ad hoc in nature can be addressed individually, other risks are managed by way of the creation and adoption of a policy. Many of the policy mechanisms are detailed in the MAH Inquiry Belfast Trust Module 3 witness statement, but should the MAH Inquiry wish information on a particular aspect then the Belfast Trust will endeavour to provide it.

Monitoring and Auditing

185. There are many monitoring and auditing mechanisms at different levels within the Belfast Trust, designed to help the organisation monitor performance levels.

186. At Board Level, the Trust Board produces:

a. An Annual Report (which includes a performance report, an accountability report and financial statements)

b. A Quality Report

c. A Delegated Statutory Functions Report

187. The Trust Annual Report, samples of which can be found behind Tab 21 in the exhibit bundle, include:

a. A Performance Report which reflects on the Belfast Trust's purpose and activities over the previous year and analyses the Belfast Trust's performance against targets and performance indicators including the Ministerial Commissioning Plan Directions Performance Targets.

b. An Accountability Report which contains three sections: the Corporate Governance Report, the Remuneration and Staff Report, and the

Accountability and Audit Report. Together, these reports explain how the Belfast Trust has met its key accountability requirements.

c. Financial Statements which include a set of accounts prepared in accordance with Article 90(2)(a) of the Health and Personal Social Services (Northern Ireland) Order 1972, as amended by Article 6 of the Audit and Accountability (Northern Ireland) Order 2003.

188. The Quality Management System ("QMS") is an approach to performance management, quality improvement, accountability and assurance processes. It is managed through a tiered accountability process with comprehensive reporting against key performance standards and targets related to six quality parameters. The Belfast Trust Annual Quality Report, examples of which can be found behind Tab 22 in the exhibit bundle, highlights the measures, achievements and progress of the Belfast Trust against a number of key metrics within the QMS. The present key metrics are safety, experience, effectiveness, efficiency, timeliness and equity. These are set against the priorities of the Belfast Trust and key measures to inform the outcomes for the previous year.

189. Delegated Statutory Functions Reports ("DSF Reports"), examples of which can be found behind Tab 23 of the exhibit bundle, provide an overview of the Belfast Trust's discharge of its statutory functions in respect of services delivered by the social work and social care workforce (the social care workforce). It addresses the assurance arrangements underpinning the delivery of the relevant services across the individual Service Areas, outlines levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Functions and identifies ongoing and future challenges in the provision of such services.

190. The reports are in accordance with a format specified by the Department of Health through the SPPG (formerly HSCB).

191. DSF Reports, which are provided annually, include; a strategic overview of the Belfast Trust's performance in relation to the discharge of its statutory functions across the respective Service Areas, Individual Service Area reports, workforce information returns, and an overview return on the Belfast Trust's social care workforce. The Belfast Trust also provides an interim DSF Report 6 months into the year which provides a Progress Report per Service Area in relation to issues raised by SPPG (formerly HSCB) in relation to the previous DSF report. An example of an interim DSF report can be found behind Tab 24 in the exhibit bundle.

192. The Committee structures are also highly involved in the monitoring and reporting side of governance. As I have explained above, the Standing Committees of the Trust Board have sub-committees referred to as Steering Groups. The Steering Groups have Directorate representation at either Director or Co-Director Level. Each Directorate provides budget reports, managerial reports, performance reports, Health care associated infection reports, KPI and Infographics reports to the various Steering Groups as part of the QMS. The Chair of the Steering Groups thereafter report upwards to the Standing Committees. The purpose of this is to try to ensure that performance is monitored in all areas, and at all levels, in order to create a line of sight for the Trust Board over all of the Belfast Trust's business.

193. The Standing Committees then report to the Trust Board on the basis of the reports received, and their own work, which assist in the compilation of the Trust level reports.

194. An understanding of this structure is perhaps easiest gained by reading some samples of the Terms of Reference for the Standing Committees, Steering Groups and Advisory Groups/Teams which can be found behind Tab 19 in the exhibit bundle.

Topic 7 – Interrelationship between Trusts re patients admitted to MAH

195. In setting out the information I have below I have had the specific assistance of the following people Paul Devine, Marie Heaney, Peter Sloan and Joanna Dougherty. If there are any matters arising out of what I have said below, which are of particular interest to the MAH Inquiry, the Belfast Trust will happily have those issues considered within the Belfast Trust and thereafter provide further information to the MAH Inquiry.

196. The relationship between the five health and social care trusts in Northern Ireland (Northern, Southern, Western, South Eastern and Belfast Trusts), in respect of patients admitted to MAH, may be considered similar to how MAH has developed itself.

197. MAH was the first hospital for learning disabilities in Northern Ireland. Consequently, it was a regional hospital, caring for patients from all over Northern Ireland. The North and West Belfast Health and Social Services Trust (which ran MAH between 1999 and 2007) had Service Level Agreements with each of the then four Health and Social Services Boards in Northern Ireland. Those Service Level Agreements governed the provision of care to patients who originated from all over the region.

198. When the present five Health and Social Care Trusts were created in 2006/2007, the Belfast Trust became responsible for MAH. However, the residents of MAH who did not come from the Belfast Trust service area remained at MAH. The relevant Health and Social Care Trust which any MAH patient originated from, was referred to as the 'Trust of origin' for that patient.

199. With time, the opening of a hospital for patients with a learning disability within the Western Trust, and the Southern Trust, reduced the need for patients from each of those areas to be admitted to MAH. It is best practice, for continuity

of care, that a Health and Social Care Trust treats a patient within the Trust's own service area when at all possible.

200. The relationship between Trusts for patients within MAH exists from the point of admission to the point of discharge. It continues for some patients who do not originate from the Belfast Trust but are resettled within the Belfast Trust service area.

201. Before 2018/2019, the practice was that all individuals with a learning disability who were deemed to require an acute psychiatric bed were admitted to learning disability hospitals. In practice this meant that MAH was the default option for patients from the Belfast, Northern and Southern Trusts with learning disabilities or those experiencing severe behavioural disturbances. In mainstream adult mental health services, the Home Treatment Team acts as the gateway system for inpatient admission in order to manage admissions but a similar service did not exist in learning disability. The Belfast Trust took steps to address this and held two inter trust meetings to establish proper structures for admission requests and to begin to redefine admission criteria. From that meeting, the Trusts adopted the pre-admission screening from the English CTR (Bluelight meetings) and over time admission criteria were agreed.

202. The receiving into MAH of patients from other trusts was more commonly the case for patients from the Northern Trust and the South Eastern Trust, neither of which had developed its own hospital provision for patients with a learning disability. The Belfast Trust was therefore commissioned to provide inpatient services for patients from the South Eastern and Northern Trust as well.

203. Of the 29 patients present in MAH today, only 13 patients (or less than 50%) are patients who originate from within the Belfast Trust. When a patient is admitted to MAH, that patient is no longer funded by the Trust of origin, and the

financial implications of that patient's admission to MAH fall to be met by the Belfast Trust.

204. During admission, community staff from the Trust of origin were invited to PIPA meetings. Any incidents, complaints or safeguarding issues that arise in relation to a non-Belfast Trust patient within MAH, are dealt with by the Belfast Trust, but as a matter of good practice, the Trust of origin should, where reasonably possible, be kept informed and the processes within the Belfast Trust generally require referral to the Trust of Origin for their consideration. .

205. When a non-Belfast Trust patient is admitted to MAH each patient should retain their community Key Worker and a Care Co-ordinator from the Trust of origin, as designated and required under the 2010 publication "Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services."[5], which can be seen behind Tab 25 in the exhibit bundle. These have become colloquially known within MAH as resettlement key workers.

206. The responsibility for financing the patient's care, safeguarding the patient and ensuring that the patient receives quality care while they are resident in MAH, which is met by the Belfast Trust, is in contrast to the position whereby a patient in MAH is resettled into the community within the service area of the Belfast Trust. Where that is the case, the community placement is funded by the Trust of Origin, which is also responsible for the care management responsibilities of the patient. Should the patient be resettled into a facility which is owned and operated by the Belfast Trust, this is given effect by way of a recharge agreement between the Belfast Trust and the Trust of Origin. If the patient is instead resettled into the care of an independent service provider, the Trust of Origin enters into an agreement

[5] May 2010 "Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services".

directly with the independent service provider. If the patient returns to the service area of the Trust of origin, then all costs are met by the Trust of origin.

207. Unfortunately, the Belfast Trust has found that the administrative complexities regarding Trust of Origin funding and care management responsibilities have been identified as creating organisational disincentives to the strategic commissioning and delivery of services to people where they wish to live now, irrespective of where they were born or raised.

208. In the process of discharging a patient, structures were put in place to encourage MDT input and regular meetings were held with other Trusts regarding progress for patients. There are regular meetings between SPPG (formerly HSCB) and the Trusts involved. There are also various inter-trust Development Meetings about developing schemes and opportunities for the patients within MAH, followed by individual meetings to review patients in MAH, which involve the care manager leads from the Trust of Origin for that patient.

209. The Community Treatment and Support Team within Intellectual Disability Services (formerly Learning Disability Services) in the Belfast Trust engages with each patient equally, regardless of their Trust of Origin. Their role is set out below in relation to community provision.

210. It is perhaps of note to the MAH Inquiry that the interrelationship between Trusts extends further within Intellectual Disability Services than just those patients who are admitted to MAH. In 2007, the Belfast Trust employed and financed all of the clinical psychiatrists which serviced the Northern Trust, Belfast Trust and South Eastern Trusts. Responsibility for clinical psychiatrists within the Northern Trust service area has since been transferred to the Northern Trust. However, to date, clinical psychiatrists which provide services to the South Eastern Trust are still employed by the Belfast Trust.

Topic 8 – Explanation of structures in place to promote quality of care at MAH

211. It is difficult for any one person within the Belfast Trust to satisfactorily address all the matters that are covered in what is set out below. In order to provide the below information to the MAH Inquiry I have had the assistance of the following people: Tracy Reid, Rhonda Scott, Joanna Dougherty, Catherine O'Callaghan and Kim Murray. If there are any matters arising out of what is said below, which are of particular interest to the MAH Inquiry, I will undertake to have those issues considered further within the Belfast Trust and thereafter provide an additional response to the MAH Inquiry.

212. It is perhaps helpful at the outset to reflect on the meaning of quality of care, which is defined locally by the then DHSSPS document 'The Quality Standards for Health and Social Care'. The five quality themes are:

a. Corporate Leadership and Accountability of Organisations;

b. Safe and Effective Care;

c. Accessible, Flexible and Responsive Services;

d. Promoting, Protecting and Improving Health and Social Well-being; and

e. Effective Community and Information.

213. The structures which the Belfast Trust has in place to achieve these themes and thus promote quality of care can broadly be broken down into organisational structures, policies and procedures, routine reporting mechanisms, reactive reporting mechanisms and patient engagement.

Organisational Structures

214. Many structures which are in place to promote quality of care at MAH have already been discussed under Topic 6 through both the committee structure and the directorate structure. The organisational structure of the Belfast Trust is designed to create lines of accountability, both managerially and professionally. The complex and extensive governance systems are designed to try to maximise patient safety in respect of the provided services, and to deliver the services to the highest standards reasonably possible.

Policies and Procedures

215. There are various policies and procedures in place, which are dealt with more fully in the Belfast Trust module 3 witness statement, which are designed to promote quality of care within MAH. Recent developments in this regard which may be of interest to the MAH Inquiry include a review of the adult safeguarding process and the seclusion policy amongst others.

Routine Reporting Mechanisms

216. Every managerial role has mechanisms designed to make the relevant manager aware of any quality of care concerns. These mechanisms include regular meetings, reporting mechanisms and audits and staff training.

217. Reports and audits have already been discussed in the context of the committee structures. Of particular note to the MAH Inquiry in relation to promotion of the quality of care will be Key Performance Indicators which are mechanisms to provide assurance in relation to quality of care, and SITREP Reports which were established in the wake of the allegations of abuse within MAH. Examples of the SITREP reports can be found behind Tab 26 in the exhibit bundle. These

mechanisms generate weekly reports on a number of key Care Metrics designed to measure and monitor safety.

218. The structures and processes in place relating to staffing levels and professional training and education are also key mechanisms to promote quality of care within MAH, having the objective of providing the right care at the right time in the right place. These are dealt with more fully within Module 4. The MAH Inquiry will probably already be aware of the extreme difficulty in securing suitable numbers of qualified learning disability staff, and the significant problems this creates.

219. There are also meetings which occur at each level of the organisational structure to provide unbroken lines of accountability. Meetings which take place within the Directorate Structure are:

Patient Specific

220. There are various methods of ensuring that the particular care that a patient receives is appropriate to their needs and is of good quality. These include PIPA meetings which relate to each specific patient in MAH. The PIPA process ensures needs are met and identified in a timely way and ensure robust formulation and early discharge planning where clinically appropriate. For a period of time following the allegations of abuse at MAH, these were conducted on a daily basis, enabling multi-disciplinary discussion about patient's care and treatment each morning.

Ward Level Meetings

221. Every morning on a ward in MAH, there is a short safety huddle, which is a multidisciplinary briefing. These were originally introduced into the Belfast Trust between 2007-2009 as part of the Institute for Healthcare Improvement work. They have since become much more robust and focused as the Belfast Trust employs the

Charles Vincent Model. The safety huddle essentially poses the questions, "Has patient care been safe in the past?", "Are our clinical systems and processes reliable?", "Is care safe today?", "Will care be safe in the future?" and "Are we responding and improving?".

222. At Ward level, there are also weekly Clinical Improvement Meetings and weekly Ward Meetings, the latter of which are convened by the Ward Manager and attended by all staff on the ward. When required, the Assistant Service Manager with oversight of the ward may also be in attendance.

Care Delivery Unit Level Meetings

223. A number of meetings have, throughout the existence of the Belfast Trust, taken place at a Care Delivery Unit Level at MAH (or previous iterations of the operational unit encompassing MAH) which include:

a. Weekly meetings which take place between the Service Manager of MAH and the Senior Nurse Managers/Assistant Service Managers to ensure that the Service Manager is aware of any issues or updates across the operation of MAH.

b. The Service Manager also meets with Senior Nurse Managers/Assistant Service Managers as well as all Band 7 staff on site on a weekly basis.

c. The Professional Senior Nurse Forum, chaired by the Service Manager for MAH, focused on professional nursing issues and was attended by Senior Managers with input into MAH such as the Community Integration Manager, the Clinical and Therapeutic Services Managers and the Nurse Development Lead.

d. The MAH Core Group is a meeting that was originally created during the time of the North and West Belfast Health and Social Services Trust. The membership of the meeting has varied throughout the primary date range of the MAH Inquiry, but the consistent characteristics are that it was a meeting which created Divisional Oversight over MAH, some of the attendees being in Managerial Roles at Divisional level, but being solely concerned with topics concerning MAH.

Divisional Level Meetings

224. As explained within Topic 6, broadly speaking, from the inception of the Belfast Trust, there has been a Division dedicated to Learning/Intellectual Disability Services, regardless of whether this was conceptualised as a Service Area or eventually as a Division. There has always been a meeting at this Divisional Level which was chaired by the Co-Director (or equivalent role) and brings together the Service Managers and other roles at Divisional Level to discuss issues across the Division.

225. The Operational Working Group was formed in response to the allegations of abuse in MAH. It is chaired by a Trust Service Manager within Human Resources and its membership includes representatives from the PSNI and RQIA. The Trust representatives on the Group include senior managers from Human Resources, Adult Safeguarding, and Nursing. The Operational Working Group initially met on a weekly basis and now meets on an approximate three-weekly basis with the dual purpose of keeping under review all actions and decisions taken in relation to staff implicated in the MAH investigation, and providing assurance of the safe management of all alleged safeguarding concerns and /or information.

226. The Safeguarding Governance Group was formed in response to the allegations of abuse in MAH. It is chaired by the Belfast Trust Executive Director of Social Work and its membership includes representatives from the PSNI, RQIA,

Department of Health, and Strategic Planning and Performance Group (formerly Health and Social Care Board). The Safeguarding Governance Group meets as required to provide oversight and governance on the safeguarding process, and to ensure co-ordination between the key agencies within the Operational Working Group.

Directorate Level Meetings

227. There has always been a directorate level meeting for the directorate within which MAH sits. The Directorate structure has changed over time. It was originally the "Adult Social and Primary Care" Directorate. It is presently the 'Mental Health, Intellectual Disability and Psychological Services' Directorate. Any issues or matters related to MAH are reported upwards to be discussed at this Directorate Meeting.

228. The meetings which occur within the Corporate Directorates are also relevant to promoting the quality of care at MAH and consider professional issues arising out of MAH through the dotted line. For example, should nursing or medical professional issues arise, they will be escalated through the professional lines of accountability to the various meetings which occur throughout the levels of the relevant Corporate Directorate. Equally, should a financial issue arise, it would be escalated not only through the Directorate for Mental Health, Intellectual Disability and Psychological Services but also through the levels or the Finance Directorate.

Board/Executive Level Meetings

229. In addition to the routine Trust Board and Executive team meetings, bespoke structures were also introduced at executive level to try to respond to the developing situation at MAH in late 2017. These included:

a. Muckamore Abbey Hospital Directors Oversight Senior Co-Ordination Group. This was a Director led group that met on a weekly basis between 27 November 2017 and 1 October 2019. The membership of the group was made entirely of Directors and was established to provide oversight on all actions being taken in respect of ensuring all clients were safely cared for within the Learning Disability Service in MAH. This group was also, during the course of its existence, referred to as the 'MAH Directors Oversight Meeting' and the 'Directors Oversight Senior Coordination Group".

   The Director Oversight Group received weekly reports from various sources including the Operational Management Group (discussed above). Two members of the Director Oversight Group also attended at Muckamore Abbey Hospital site for an afternoon each week. This was to meet with the senior team and to offer all staff of all professions the opportunity to meet and discuss any issues, concerns or inquiries they may have. Members of the team also visited some wards.

b. The Intellectual Disability Oversight Group replaced the above MAH Directors Oversight Senior Co-Ordination Group and existed between 23 October 2019 and 12 August 2020. The purpose of this group was to ensure that the four different operational elements of Intellectual Disability services, including the historic CCTV safeguarding concerns, and any subsequent disciplinary hearings, were co-ordinated.

c. The MAH Leadership & Governance Review Meeting replaced the Intellectual Disability Oversight Group. It existed between 19 August 2020 and 24 January 2022. The purpose of this group was to consider the factual accuracy of the 2020 Leadership and Governance Review Report, follow up key issues raised in the Report and action matters arising out of the Report.

d. The MAH Hospital Departmental Assurance Group (MDAG) was created to provide the Department of Health with assurance of the effectiveness of the response to the 2018 independent Level 3 SAI Investigation which produced the 'A Way to Go' Report. MDAG began on 30 August 2019 and continues to operate on a quarterly basis.

Reactive Mechanisms

230. There are a collection of what I am terming, for the purposes of this statement, reactive procedures in place within the Belfast Trust and MAH which also aim to promote the quality of care. These are structures or mechanisms that only become relevant when a certain event occurs. Examples of such mechanisms are the procedures in place to manage complaints, safeguarding incidents, serious adverse incidents, and early alerts. I understand that the policy background to these mechanisms is dealt with more fully in the Belfast Trust Module 3 witness statement. For present purposes I observe that these procedures are in place to ensure and promote quality of care by aiming to reduce the number of reportable incidents by properly managing risk factors that lead to such incidents, properly manage and reduce the effect of any that do occur, and learning from previous experience to reduce future incidents.

Patient Engagement

231. Patients and their family members are encouraged to provide feedback to the Belfast Trust through real time feedback from service users. Feedback can be given informally or more formally through the giving of a compliment or conversely a complaint. Complaints are processed in accordance with the relevant policy which is addressed in the Belfast Trust Module 3 witness statement.

232. There have also been a number of ways in which the Belfast Trust measures the patient experience, and gives patients and their families platforms to engage with the Belfast Trust in relation to the care received. These include:

a. The Society of Parents and Friends of MAH was formed in 1962 to safeguard the well-being of patients in MAH. The Society formed a means of giving patients and their families a voice.

b. In February 2008, the Belfast Trust established a contract with 'ARC' (the Association for Real Change) to support a group of patients whose discharge from hospital was delayed because of a lack of community resources. This was to allow them to tell their stories and help decision makers understand what it is like to live in hospital, and what they need to be able to move on. The MAH Group of TILII ('Telling it Like it is') was therefore formed. In 2008, one of the members of TILII MAH joined the resettlement team as a patient's representative. TILII made representations to various levels of the political structure of Northern Ireland including the Northern Ireland Assembly and Antrim Council. A Muckamore TILII Advisory Group Meeting was organised in which Senior Management from MAH met with TILII representatives. TILII continue to operate within MAH today. An example of a TILII newsletter can be found behind Tab 27 in the exhibit bundle.

c. Patient Forums are ward based forums where patients are supported by ward staff to identify issues or concerns and provide patients with an avenue to try to resolve such issues.

d. Patient Questionnaires/Patient Experience Surveys (in easy read format) are often provided to patients to seek their feedback and on foot of which to improve the patient experience. Examples of these questionnaires and associated analysis can be found behind Tab 28 in the exhibit bundle.

e. Parents and Carer's Forum are further forums which enable parents and carers a platform to vocalise any concerns or issues that they would wish to raise.

f. Patients also benefit from advocacy services through either Mencap or Bryson House Advocacy Services. These services aim to assist patients in vocalising their views, concerns and issues.

233. The above structures intend to provide patients with the ability to have an input into their control so that the patient is at the centre of their care.

Topic 9 – Outline of provision of community based services

234. In setting out the information I have below I have had the specific assistance of Tracy Reid, Fiona Rowan and Kim Murray. If there are any matters arising out of what I have said below, which are of particular interest to the MAH Inquiry I will happily undertake to have those issues considered within the Belfast Trust and thereafter provide further information to the MAH Inquiry.

235. As previously explained, the Belfast Trust is organised into Directorates which are, broadly speaking, divided by the type of care provided. There is no one Directorate for community based services in the Belfast Trust. Community Service Teams are integrated throughout the Belfast Trust's Directorates and specific to the type of care they provide.

236. By way of example, the community team which provides care for patients who have been resettled from MAH, sit within the Division of Intellectual Disability Services, which sits within its own larger Directorate.

237. I will therefore focus in this witness statement on outlining the provision of community-based services within Intellectual Disability Services, but should any further detail be sought in relation to other community-based services, I will endeavour to assist the MAH Inquiry with that request.

238. As I have previously said in relation to topic 6, the Division of Intellectual Disability Services is broken down into smaller Care Delivery Units. One of those Care Delivery Units has always been centred around MAH. The other Care Delivery Units have centred around community-based learning disability services and corporate support. The number of Care Delivery Units which have existed within learning disability have varied throughout the primary date range to adapt to the growing needs in each area. For example, the use of independent service providers/commissioned services has grown within Intellectual Disability Services, and it now therefore has a specific Care Delivery Unit dedicated to it, whereas in 2007, this was part of a wider operational area. Should the MAH Inquiry seek further information on the structure of the Care Delivery Units which existed at any given time, I will endeavour to provide the further information sought.

239. Regardless of the structures within which they have been situated, the work covered by the community services teams may be broadly broken down into five parts:

a. Residential Care;

b. Supported Living;

c. Day Services;

d. Community Teams;

e. Commissioned Services and Care Management.

240. These teams are interdependent; for example, a service user who has an appointed key worker from the community team may be in residential care and also access day services.

241. Residential Care is the residential accommodation and care provided by the Belfast Trust within Belfast Trust owned and operated facilities, such as Cherry Hill, Greystone Centre or Shaws Avenue.

242. Supported Living is similar to the above, but the service user may not need 24/7 care and can live more independently. Supported Living has more recently been grouped within the same care delivery unit as Residential Care.

243. Day Services are relatively self-explanatory and includes the day centres which are owned and operated by the Belfast Trust in the community such as Everton Centre, Mica Drive and Fallswater. For the avoidance of doubt, Day Care Services within MAH fall under the Service Manager for MAH, and do not fall within day services in the community. Day Services was historically grouped with supported living services but has more recently become a separate care delivery unit.

244. The Community Teams Unit comprises:

a. Community Teams whose work is divided by the locality within the Belfast Trust service area that they operate within e.g. East Belfast Community Team;

b. The Adult Safeguarding Team;

245. Community teams also receive input from the Allied Health Professionals. It is within the Community Teams unit that you will find community key workers. Each patient in MAH will have a community key worker.

246. Commissioned services are any services provided by an independent service provider within Intellectual Disability Services, also referred to as a commissioned service. The service which is being provided can be any combination of residential living, supported living or day services and domiciliary care. Care Managers within this team also have responsibility for the co-ordination of care for those people accessing care packages and community supports.

247. There are currently five care delivery units within the Division of Intellectual Disability Services. The four which relate to community services are "Commissioned Services and Resettlement", "Community Treatment and Support", "Residential and Supported Living" and "Day Opportunities". The fifth relates to MAH.

248. As I have said, these services are not mutually exclusive. There are some service users with a mild learning disability who may only have ever required input from the community team. However, service users with a severe learning disability, such as those resettled from MAH, will have had involvement from many individuals across these teams.

249. The community teams within Intellectual Disability Services also do not operate in a vacuum. They have joint input from other teams as and when required. For example, should a service user in the community also have addiction issues, the community team can seek the assistance of the addictions team. In Intellectual Disability Services, the team that input is sought from most often is Psychological Services who are incredibly helpful, particularly when dealing with commissioned services as will be referred to below. Equally, they have input into MAH as and when required, which is most often in the context of resettlement.

250. In order to fully explain how the different parts of community services interact within the context of resettlement it is perhaps best that it is explained by way of example. Within this example, we will presume that no Trust other than the Belfast Trust is involved. This is an accurate depiction of the process as it looks now, the labels and titles which are referred to, will have changed over time.

251. Every patient within MAH has a resettlement plan. That plan sets out what needs to be put in place for that patient to be resettled into the Community. There are higher level conversations within the Division to consider how those needs can be met. Each patient has a care manager, from the community team of the Trust of Origin. Conversations are also had with those within residential and supported living to assess whether there is any placement within that unit which may be appropriate. Generally, however, patients from MAH require placements within commissioned services.

252. Therefore, patients who are presently resident in MAH and have a resettlement plan will generally require commissioned services. This increased need for commissioned services led to the creation of a stand-alone care delivery unit in 2019 titled "Commissioned Services and Resettlement", as commissioned services and resettlement now almost universally go hand in hand.

253. The Commissioned Services and Resettlement Team performs two functional roles in securing resettlement. The role of the Community Integration Co-ordinator (of which there are presently two) is to work to help source and plan for accommodation and co-ordinate the different professionals involved in planning that placement. When a potential placement is identified, the Community Integration Co-ordinator will identify all the areas that need to be developed and planned to achieve a successful resettlement and will co-ordinate/chair and oversee a number of meetings with the hospital MDT and the Trust of Origin's Community Team to progress this work. This will include, for example, attending

environmental meetings to ensure that the building meets the needs as identified by the patient's MDT team. This is so that if, for example, the identified placement has a kitchen that needs to be partitioned off, that work will be commissioned and actioned. This role often involves care planning, financial planning, co-ordinating the patient's families and attending "best interests" meetings etc. In summary, the role is to ensure all of the correct people are sitting around the table and that there is an action plan which is being properly implemented, centred around the needs of the patient. Despite being part of community services, the Community Integration Co-ordinator spends a lot of time in MAH working with the patient's MDT and understanding the needs of the patient.

254. The Community Integration Co-ordinator also facilitates the involvement of various services within the community team, and within the allied health professionals and other services within the Belfast Trust. For example, Psychological Services have been integral to resettlement and discharges. Psychological Services provide the Positive Behaviour Support Plans for the patient and often provide training to the independent service provider in respect of that support plan. Some independent service providers are completely new staff teams and Psychological Services often supplements specific training on how to support the patient with managing their behaviours. Another example is occupational therapy input which may be required in determining the suitability of a physical building or adaptations required for that patient's needs.

255. The Operations Manager for Care and Management within Commissioned Services and Resettlement works with the independent service provider in an operational manner. The Operations Manager will ensure that there is a care plan in place, liaise with the independent service provider using that care plan as the basis upon which they will deliver care and assess the appropriate costs of doing so. The independent service provider is then expected to produce its own care plan which will meet the patient's needs.

256. There is now also a Governance Lead solely dedicated to governance within commissioned services who sits within Commissioned Services and Resettlement. As the commissioner of the service, the Belfast Trust should be kept informed of any incident that occurs in the provision of the service to the service user. The Governance Lead ensures that the responsibilities and duties of the Belfast Trust are fulfilled in respect of commissioned services within Intellectual Disability Services and responds when there are quality issues to seek assurances that issues are addressed and care is safe.

257. When a patient is from a Trust other than the Belfast Trust this adds an additional layer of complexity as the professionals involved in the decision making, and who must be liaised with, then include the community care professionals from another Trust and that other Trust's budgetary professionals.

258. When a patient from MAH is resettled the patient's Clinical Psychiatrist from the Belfast Trust continues to care for that patient in the initial months of their resettlement, in an attempt to assist with continuity of care. Other professionals from the Belfast Trust such as care workers will also often be involved. However, the Trust of Origin should in theory assume responsibility for the patient's care upon resettlement.

Conclusion

259. The topics which have been identified within this module are each extensive. When taken with the wide primary date range of the MAH Inquiry's Terms of Reference, it means, inevitably, that there is very extensive information having to be addressed in this witness statement. The Belfast Trust has endeavoured to gather and to summarise that information in a manageable way for the assistance of the MAH Inquiry.

260. In the time available it has not been possible to outline all the ways in which the various governance arrangements have evolved throughout the duration of the Belfast Trust, nor all the ways in which significant time and resources have been invested by the Belfast Trust to strengthen and improve governance arrangements. It has also not been possible to give a detailed explanation of each and every governance system and structure which existed at any one time. If there are any matters about which the MAHI Inquiry would like further detail, then the Belfast Trust will be happy to supplement what is said in this statement, and to address any particular matters of interested to the MAH Inquiry.

261. As indicated during the course of the statement, the import of any prevailing directions or guidance provided by the Department of Health, the PHA or the SPPG (and their former iterations) at any given time is also of considerable importance to understanding how matters developed within the Belfast Trust.

Declaration of Truth

262. The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the documents which, collectively, the contributors to this statement believe are necessary to address the matters on which the MAHI Panel has requested the Belfast Trust to give evidence.

Signed: June Champion

Dated: 10 March 2023

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