Muckamore Abbey Hospital Inquiry
Witness Statement

Statement of Mark McGuicken, Director of Disability and Older People, Department of Health
Date: 13 February 2023

I, Mark McGuicken, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made on behalf of the Department of Health (DoH) in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

In exhibiting any documents, I will use my initials "MMcG" so my first document will be "MMcG/1".

Section 1: Qualifications and position

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

1.2. As Director of Disability and Older People, I am a member of the Senior Management Team of the Department of Health. I report directly to the Deputy Secretary heading up the Social Services Policy Group.

1.3. As the Director of Disability and Older People, I am an Assistant Secretary and the Department's senior advisor to the Minister of Health on policy for older people and people with disabilities, with responsibility for developing and reviewing Departmental policies which underpin the delivery of health and social care services for older people

and people with disabilities.

1.4. I have overall policy responsibility for Special Education Needs, Learning Disability, Physical and Sensory Disability, Autism, Adult Safeguarding Legislation, Gender Identity, Care Homes, Domiciliary Care, Carers, Dementia and the Reform of Adult Social Care. I also have policy responsibility for Muckamore Abbey Hospital. This role includes oversight of the Muckamore Departmental Assurance Group (MDAG) and acting as the Departmental representative on the Learning Disability Resettlement Oversight Board.

1.5. I have been a Civil Servant for more than 32 years working mainly in the Northern Ireland Office, the Department of Justice and the Executive Office. I was appointed to the Senior Civil Service when I took up my current role in the Department of Health in September 2021.

Section 2: Modules / Topics to be addressed

2.1. This statement is in response to the DoH Rule 9 request letter dated 9 December 2022. I note that the numbering of the section 3 requests is at odds with the Inquiry's 'Evidence Module 2023'. I have decided to use the numbering in the Evidence Module 2023 for the titles in the Rule 9 request letter. This issue was raised with the Inquiry on 27 January.

2.2. In this statement I have set out a description of the policies and procedures relevant to the topics set out the Inquiry's Rule 9 request of 9 December 2021, which I or my Directorate have first-hand knowledge of or responsibility for.

2.3. Where policies or procedures relate to the responsibilities of other business areas within the Department, or those of external organisations, I have set out a description of these to the best of my knowledge and outlined where those responsibilities sit within the

structure of the Department and/or the Health and Social Care ("HSC") system. I have included a HSC Governance Structure at MMcG/1. I have also included a list of abbreviations that I have used throughout my statement at MMcG/2.

2.4. My recent appointment to the Department means I have limited first-hand knowledge of the policies and procedures set out. In preparing this statement, I have relied on a thorough review of the documentary evidence held by the Department and I have discussed with colleagues who have a first-hand experience of the matters described.

2.5. Notwithstanding these efforts, however, it remains possible that in some sections of my statement there may be gaps in the policy journey for the full period covered by the Terms of Reference (ToR), from December 1999 to June 2021. The primary reason for this is due to a lack of corporate knowledge within the Department and being unable to locate some documentation evidence. All efforts will be made between the written and oral statement to bridge this gap.

2.6. In my statement I have endeavoured to provide the panel with a summary of the evolution of the policy landscape in each of the modules specified in the Inquiry's letter to the Departmental Solicitors Office of 9 December 2022, which states "*the primary objective of this phase of the evidence is to ensure that the Panel is fully informed of the legal and regulatory framework, the organisational structures that are relevant to the Terms of Reference and the relevant policies, procedures and practices that were applicable during the timeframe with which the Inquiry is concerned. It is anticipated that the Inquiry will wish to hear further evidence at a later juncture to address the adequacy and effectiveness of the systems and processes in place at the relevant time."* My statement therefore does not attempt to either assess how Health and Social Care Trusts implemented individual policies or procedures; nor the impact, effectiveness or the adequacy of

any of the policies or procedures I will detail.

2.7. There may also be some areas of overlap between my statement and that of Brendan Whittle, who will be making a statement on behalf of Strategic Planning and Performance Group (SPPG) due to the close working relationship between my Directorate and SPPG colleagues.

2.8. Before I begin my statement, the panel will be aware from the Department's opening statement that the name of the Department has changed over the period of the Inquiry's terms of reference, from the Department of Health, Social Services and Public Safety (DHSSPS) in December 1999 to the Department of Health (DoH) in 2016. In my statement, I will also include some references to the Department's role prior to December 1999 when the Department was known as the Department of Health and Social Services (DHSS), where this has some relevance to the Inquiry's work. For clarity, I use the shorthand of 'the Department' when I refer to it in this statement.

2.9. Before I move to address each of the modules in turn, I will provide the panel with a brief summary of the relevant policy and legislative landscape within which the Department operated for the period covered by the Inquiry's terms of reference.

2.10. The Department's powers derive from the Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order) and subsequent amending and additional legislation.

2.11. On 1 January 1974, the Ministry of Health and Social Services became known as the Department of Health and Social Services. On 1 December 1999, the public safety functions of the Department of the Environment were transferred to the renamed Department of Health, Social Services and Public Safety (DHSSPS). The Department was subsequently renamed the Department of Health on 9 May 2016.

2.12. On 1 September 1972, 4 Health and Social Services Boards (HSSBs), the Eastern, Northern, Southern and Western Boards, were established under Article 16 of the 1972 Order. The Health and Personal Social Services (Establishment and Determination of Areas of Health and Social Services Boards) Order (Northern Ireland) 1972 determined the geographical area of each Board and specified its administrative Districts.

2.13. Article 17 of the 1972 Order made provision for the key functions of the Boards in respect of primary and general medical services and personal social services. The Department made provision for and oversaw the Health Service through those four regional Boards.

2.14. During the early 1990s, the changes introduced by the UK Government White Papers *"Caring for People"* and *'Working for Patients'*, (DoH, 1989) respectively set out proposals for improving community care services and health services in England and Wales. The equivalent Northern Ireland policy document, *'People First'* that I have included at MMcG/3, introduced for the first time a division between the purchasing and provider roles within health and personal social services in Northern Ireland.

2.15. The role of HSSBs as coordinators, purchasers and quality controllers was strengthened relative to their primary role at that time, as service providers.

2.16. Under the '*People First'* policy reforms, HSSBs as commissioners and purchasers of services, were reconstituted as commissioning bodies, responsible for assessing the health and social care needs of their resident population, strategic planning to meet need and the development of purchasing plans.

2.17. *'People First'* required HSSBs to promote a mixed economy of care and a range of providers to maximise user choice and ensure the economic,

effective and efficient delivery of services.

2.18. The Health and Personal Social Services (Northern Ireland) Order 1991(the 1991 Order) gave effect to these changes and enabled health services bodies to enter into arrangements (HSS contracts) for the provision of goods or services to or by them.

2.19. Central to the community care reforms in England and Wales in the early 1990s was the concept that hospitals and community health providers were to be given the option to become self-governing Trusts.

2.20. Article 10 of the 1991 Order created the new Health and Social Services Trusts to provide the health services. The first of these were established in shadow form in 1993 as corporate bodies, managerially and administratively independent of HSSBs.

2.21. The Chair of each Trust was appointed by the Minister and was directly accountable to the Minister. The Trusts were established as ‘autonomous self-governing’ bodies, independent of the Boards but with ‘arms-length’ accountability to the Department.

2.22. HSSTs were statutorily independent organisations within the HSC system, responsible for the delivery of health and social care services in line with Ministerial priorities, standards and targets and as commissioned by the HSSBs (and subsequently by the HSCB).

2.23. Around this time, the Department created a HPSS Management Executive to oversee performance of the HSS Trusts. One of the main objectives of the Management Executive was to ensure that standards were raised and quality improved in accordance with Departmental policy. It was responsible for the communication of Departmental policy and instruction to the Trusts.

2.24. The relationship of accountability between the Management Executive and the Trusts was set out in an 'Accountability Framework for Trusts' (1993). This was provided in a circular issued to HSS Trusts in October 1993, and I attach a copy of this at MMcG/4. It indicated that whilst the "primary accountability of Trusts is for the quantity, quality, efficiency of the service they provide", the Department was to retain "ultimate legal responsibility for the functions and will wish to ensure that both Boards and Trusts are discharging their responsibilities."

2.25. The Management Executive was discontinued in 2000 with the creation of the Northern Ireland Executive and its functions were absorbed within the traditional structure of the Department.

2.26. The number of HSSTs was reduced from eighteen to six in 2007 under the Review of Public Administration. Section 1(3) of the 2009 Act makes provision to rename the HSSTs as Heath and Social Care Trusts (Trusts).

2.27. The Regional Health and Social Care Board was established in April 2009 under Section 7(1) of the 2009 Act; it subsequently became known as the Health and Social Care Board (HSCB). It amalgamated and replaced the previous four area Health and Social Services Boards (HSSBs) that had been established under the 1972 Order.

2.28. The HSCB had a range of functions that can be summarised under three broad headings – commissioning the provision of health and social care, performance management and service improvement, and resource management.

2.29. The six Trusts provide goods and services for the purposes of health and social care. Each Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provided to individuals and the environment in which it provides them. Section 21 of the 2009 Act

placed a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and, reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

2.30. Prior to the introduction of the Health and Social Care Act (NI) 2022 (the 2022 Act), HSCTs were accountable to the HSCB for the availability, quality and efficiency of the services they provided against agreed resource allocations. They were also accountable to the Minister through the Department and the HSCB for performance against Ministerial targets including compliance with any statutory obligations.

2.31. Finally, Section 1 of the Health and Social Care Act 2022 dissolved the Regional Health and Social Care Board. Schedule 1 to the 2022 Act outlined amendments providing for the transfer of the Regional Board's functions to Health and Social Care Trusts or to the Department of Health and the amendments consequential on the transfer of those functions.

2.32. Since 1 April 2022, the Department's SPPG has undertaken the former functions of the HSCB as prescribed in the Health and Social Care Act (Northern Ireland) 2022. The former HSCB staff continue to carry out their previous roles, although they are employed by the Business Services Organisation under a hosting arrangement.

2.33. The closure of the HSCB was an important initial first step in changing the landscape in which Health and Social Care services operate. It has provided the HSC system with an opportunity to transform how it plans, manages and delivers services in line with the vision set out in *Health and Wellbeing 2026: Delivering Together'* that I have included at MMcG/5.

Section 3: Module 2a (Budget for learning disability and mental health services)

Northern Ireland and elsewhere in the UK

3.1. The allocation of funding is a key element in the prioritisation of HSC services and resources.

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

3.3. Integration provides the opportunity for comprehensive assessment of both health and social care needs, and allows the Department and commissioners to plan services on the basis of Programmes of Care (POC). A single budget has also promoted the coherent development of objectives within a unified strategic planning process, which spans acute and community-based care and services.

3.4. However, this difference in structures across jurisdictions makes it difficult to draw meaningful comparisons on expenditure.

3.5. The Department does not have access to information on allocated budgets for Learning Disability services provided in other jurisdictions. The Inquiry was informed on 4 January 2023 that the Department did not hold information for other jurisdiction and asked for direction on how to progress this aspect of the request. This is a matter of continued engagement with the Inquiry.

3.6. The Department sets the budget, reviews the prioritisation of various health and social care needs across Northern Ireland and does so

remaining cognisant of the budget allocation made available by the Department of Finance from the overall Northern Ireland block grant, provided by the Treasury on an annual basis.

3.7. The majority of overall public sector funding (Trusts may generate limited income from other sources, such as for example client contributions towards the cost of social care) for Northern Ireland is provided by HM Treasury via the Northern Ireland block grant, as part of the national spending reviews. It is based on a population driven mathematical formula known as the Barnett Formula that has been in use since 1979. Changes to the total provision for Northern Ireland are largely determined through the principle of comparability, whereby HM Treasury adjusts the Northern Ireland block grant in line with comparable programmes in England.

3.8. The Northern Ireland Executive has the discretion to allocate devolved resources within the Northern Ireland block across all departmental spending programmes. The Department sets its proposed allocations in the context of the Minister's overall priorities and objectives for the Department's public expenditure programme. Spending on health and social care currently equates to approximately 46% of the total public expenditure (revenue and capital) within the control of the Northern Ireland Executive.

3.9. The allocation of health and social care funding is an emotive topic. The Department must take difficult decisions in prioritising needs of different groups of patients and clients each of whom seeks funds to meet genuine health and social care needs.

3.10. The Department does not allocate funding on a patient-by-patient basis. It determines its priorities and then, given the funds available, budgets against those funds and allocates resources to the HSC Board (or more recently SPPG) so that in conjunction with the Health and Social Care Trusts the needs of individual patients/clients, carers and

families can be met.

3.11. In line with its responsibilities under the 1972 Order, the Department provided funding for mental health and learning disability services within its general funding of health and social care services through the four Health and Social Services Boards (HSS Boards) as the commissioning bodies up until 1 April 2009, when under the 2009 Act the four HSS Boards were replaced by a single Regional Health and Social Care Board (HSCB) which assumed the regional commissioning role. The HSCB commissioned services from the five Health and Social Care Trusts up until its dissolution on 31 March 2022, when its functions transferred with effect from 1 April that year to the Strategic Planning and Performance Group (SPPG) within the Department.

3.12. The HSCB in exercising its functions under the 2009 Act had, through the Department's Commissioning Plan Direction each year, the responsibility for commissioning health and social care services ensuring the best use of available resources, as well as improving and managing the performance of Health and Social Care Trusts.

3.13. The Commissioning Plan Direction, issued annually by the Department under Section 8(3) of the 2009 Act, set out the Minister's priorities for the HSCB and the Public Health Agency (PHA) in the commissioning of health and social care services for the year. Each year's direction is published on the Department's website and includes associated indicators against which performance is measured. The commissioning process, which includes resource and performance management, was led by the HSCB and translates the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services. The HSCB's established commissioning process involved input from key HSC stakeholders to ensure appropriate services and funding were secured whilst cognisant of existing services pressures. The commissioning cycle involves assessment of need,

prioritising need within available resources, building capacity of the population to improve their own health and wellbeing, engaging with stakeholders, securing through service and budget agreements the delivery of value for money services that meet standards and service frameworks for safe, quality care, safeguarding the vulnerable and using investment, performance management and other initiatives to develop and reform services.

3.14. I have included commissioning plan directions from 2009 to 2019 at MMcG/6, MMcG/7, MMcG/8, MMcG/9, MMcG/10, MMcG/11, MMcG/12, MMcG/13, MMcG/14, MMcG/15 and MMcG/16.

3.15. The Department also retains the usual authority and responsibilities of a parent Department in relation to direction and control of its arm's length bodies. The main principles and procedures are set out in the Department of Finance guidance *'Managing Public Money Northern Ireland 2008,'* that I have attached at MMcG/17 and are reflected in each ALB's management statement/financial memorandum, in the letter appointing its chief executive as accounting officer for the body, and in the letters appointing its chair and other non-executive board members. I will provide more detail on these governance requirements later in my statement under module 3(l).

3.16. To organise the delivery of the Department's general duty to promote an integrated system of health and social care, in allocating resources to the HSCB (and latterly SPPG) in its role as commissioner of services the Department uses a system of Programmes of Care.

3.17. A complex statistical formula, known as the Capitation Formula, is used to predict differential needs for HSC resources across five Local Commissioning Group (LCG) population areas. The formula determines each LCGs fair share of resources. These fair shares take account of the population size of each locality and is adjusted to account for age, gender and socio-economic differences.

3.18. The demand for HSC services is greater than the resources available, therefore the formula cannot guarantee that all care needs are met but does help to ensure that populations have fair access to the resources that exist. The Capitation Formula does not determine the level of investment required at Programme of Care (PoC) level; rather it provides the equitable distribution of that PoC funding by LCG.

3.19. Additional adjustments are also made as part of the formula to take into account costs that can arise when delivering services. These include an adjustment for the cost of delivering services in a rural area (rurality) and the impact that the size of a facility can have on running costs (economies of scale).

3.20. The result is a formula which indicates the fair share of available financial resources that each of the local populations should receive based on relative, not absolute need.

3.21. The formula is made up of smaller formulae based upon the nine programmes of care (PoC) that are used in the management of Health and Social Care services. This ensures the formula is reflective of any differences in service need in each PoC.

3.22. Programmes of Care within the Northern Ireland Health and Social Care service are divisions of healthcare, into which activity and finance data are assigned, to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total there are nine Programmes of Care, which I list below:

- PoC1 – Acute Services;
- PoC2 – Maternity and Child Health;
- PoC3 – Family and Child Care;
- PoC4 – Elderly Care;

- PoC5 – Mental Health;
- PoC6 – Learning Disability;
- PoC7 – Physical and Sensory Disability;
- PoC8 – Health Promotion and Disease Prevention; and
- PoC9 – Primary Health and Adult Community.

3.23. I attach a copy of Departmental definitions and guidance on Programmes of Care at MMcG/18, which remains current.

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

3.25. From 2008 to present, PoC 6 represented the third largest programme of HSC expenditure, and currently accounts for around 8% of total expenditure after PoC 1 – acute care services, with around 40% of the total expenditure, and PoC 4 – services for older people which accounts for approximately 20%.

Children and Adults

3.26. Funding for learning disability services has increased consistently over recent years with an increase in spending from £240m in 2010/11 to an expenditure in 2019/20 of £412m. This equated to around 8.6% of the total health and social care actual Trust expenditure in 2019/20. To note, this figure captures the services provided to both Adults and Children with a learning disability, but there is no way of separately identifying this split in the information held by SPPG/DoH. There may be elements of expenditure relating to both Adults and Children with disabilities classified within other Programmes of Care, although it is not possible to dis-aggregate this expenditure separately within these

PoC's.

3.27. Services for people with a learning disability are commissioned on the basis of assessed need to ensure individuals receive access to appropriate care and treatment when required, and that their families and carers are supported in their caring capacity.

Health care, social care, institutional and hospital provision and community support

3.28. I have taken these two headings together to provide a breakdown of Learning Disability spend across all these settings. I attach at MMcG/19, a spreadsheet summarising of PoC 6 spending reported by Trusts on providing learning disability services over the period 1999 to 2021, broken down by hospital services, community services and personal social services. Community services relate to health care provided outside of a hospital setting, such as for example, district nursing, health visiting, and community psychiatric nursing. Personal social services encompass personal care services provided for vulnerable people, including those with special needs, because of old age or physical or mental disability, and children in need of care and protection, therefore the expenditure listed at MMcG/19 may include extended services somewhat outside PoC 6, albeit connected to learning disability.

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

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

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

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

3.33. Specifically in relation to the costs associated with running Muckamore Abbey Hospital, in 2019 as part of contingency planning on the future role of the hospital, the Department commissioned the HSCB to carry out an analysis of the budget allocation for commissioning delivery of services at the Muckamore Abbey Hospital site over three years from 2016-17 to 2018-19. I attach at MMcG/21, a spreadsheet which was provided to the Department by the HSCB in response to this request, and which details the budget and expenditure on services at the hospital in the three years specified. More up to date information is not available at present due to financial returns being unavailable from Belfast Health and Social Care Trust during the Covid-19 pandemic.

Section 4: Module 2b (Department of health: oversight of learning disability services)

4.1. Since 1999 there have been a number of reviews and reforms of the Health and Social Services in Northern Ireland which have sought to put in place structures which are patient-led, centred and responsive.

4.2. These have included:

- the 1998/99 consultation document, *'Fit for the Future'*, at MMcG/22,
- a summary of responses at MMcG/23,
- *'The Acute Hospital Review'*, at MMcG/24, MMcG/25, MMcG/26 and MMcG/27,
- 2002's *'Developing Better Services' at*, MMcG/28,
- the 2005 *'Independent Review of Health and Social Care Services in Northern Ireland'*, at MMcG/29 and,
- *'A Healthier Future'* from 2005 at, MMcG/30.

4.3. These reviews and programmes of reform helped inform the work of the "Review of Public Administration", a NI Executive programme of reform of public administration in Northern Ireland, which commenced in 2002. In relation to Health and Social Care structures, this led to the enactment in January 2009 of the 2009 Act. This created the current health and social care system in operation in Northern Ireland and contained a requirement for the Department to produce a Framework Document setting out the priorities, objectives and relationships for each health and social care body.

4.4. In general terms, the Department currently oversees the delivery of learning disability services as part of the wider established accountability and governance arrangements for the Health and Social Care system set out in the Department's Framework Document prepared under section 5 of the 2009 Act. I attach a copy of the Framework Document at MMcG/31.

4.5. The Framework Document sets out how the strategic agenda for the HSC is determined and how priorities and targets are set, monitored and performance managed. It describes how resources are allocated, monitored and managed and how the system is held to account. The document describes governance processes and the role of

independent challenge. It is intended to be a clear, high-level framework within which the HSC bodies must operate. It is supported by more detailed governance mechanisms including the management statements and financial memoranda for each HSC organisation, which must be prepared by the Department in line with Department of Finance requirements. Nothing in the Framework Document detracts from the Department's overriding authority and accountability for health and social care. It is important to note however, that operational delivery of services is provided by Trusts who are accountable in the first instance to their Trust Board with regard to staffing and provision of services at local level. Section 6.3.iii of the HSC Framework refers.

4.6. Section 6 of the Framework sets out the specific policies, procedures and practices that are required to provide appropriate assurance to the Department that each HSC body is fulfilling its essential obligations. These requirements apply to all services and functions delivered by each HSC body and as such include services provided for people with a learning disability. I will provide further detail on these specific requirements later in my statement in module 3(I) at section 15 of my statement.

4.7. In addition to these general requirements which apply to all HSC services, a number of time limited oversight arrangements have also been established at various times since 1999 to provide additional oversight as required of learning disability services.

4.8. For example, to oversee implementation of the Bamford Vision for mental health and learning disability services, an inter-Departmental Ministerial Group chaired by the Health Minister was established in 2007 and was comprised of nominated senior officials from departments who had responsibility for targets within the action plan.

4.9. A Bamford Monitoring Group made of service users and carers was established in 2009 and supported by the Patient and Client Council to

provide an independent challenge function on the implementation of the Bamford vision. The Group's membership was made up of people who used Learning Disability and Mental Health services and their carers. Its purpose was to provide feedback from the public, service user, family and carer perspective, on service improvement in relation to implementation of the Bamford recommendations, and also to provide an independent challenge function on the extent to which the changes being put in place align with the Bamford vision. The Department provided recurrent ring-fenced funding to the PCC to support the work of the Group.

4.10. The evaluation of the second Bamford Action Plan in 2016, included a recommendation that the Bamford oversight structures, including the Bamford inter-Departmental Ministerial Group, be wound up, however due to the collapse of the Executive in 2017, this proposal did not receive Executive approval. I attach correspondence from the then Minister to Executive colleagues regarding this issue at MMcG/32. I provide more detail on the Bamford Review and its Action Plans and Evaluation reports in module 3(a).

4.11. The Service Framework Programme Board, which was set up in 2007, was chaired by the Chief Medical Officer was originally constituted as a sub-group of the Departmental Board. In 2015 the redefined terms of reference for the Board noted the core membership as Departmental policy and professional leads, with the Chief Medical Officer as Chair. This Programme Board oversaw the governance arrangements for the timely delivery of the Service Framework Programme, including the Service Framework for Learning Disability and the Programme Board ToR, that I have included at MMcG/33 and MMcG/34. I provide more detail on the Learning Disability Service Framework in modules 3(a) and 3(l).

4.12. Following the publication of the independent report into allegations of abuse into Muckamore Abbey Hospital in December 2018, '*A Way to*

Go', the Department established the Muckamore Departmental Assurance Group (MDAG) in 2019. The Group has a remit to oversee delivery of the actions in the MAH HSC Action Plan (MMcG/35), which the Department developed to address the recommendations within the 'A Way to Go' report and improve learning disability services, as well as providing assurances about the safety of services at Muckamore Abbey Hospital. Until recently the Group was jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer. While outside the Inquiry's Term of Reference, it should be noted that, following reorganisation of responsibilities within the Department, the chair of MDAG has now moved to the Deputy Secretary Social Services Policy Group and the Chief Nursing Officer.

4.13. In terms of community services, the Health and Social Care Board have a significant role to ensure that Trusts commission services in line with the Department's Commissioning Plan Direction. Funding allocations are made to each Trust using a capitation formula to enable services to be commissioned and delivered. Trusts report directly to HSCB (now SPPG) via financial monitoring systems and Delegated Statutory Functions.

Section 5: Module 3a (Policies for delivering health and social care to learning disability patients 1999 – 2021)

5.1. The current policy direction for people with learning disabilities in Northern Ireland can be traced back to the Department's policy document *'People First'* which was published in 1990 and emphasised the policy shift towards community-based care. I attach a copy of *'People First'* at MMcG/3.

5.2. For people with learning disabilities, among other things, *People First* included a commitment that no one should be required to live in long stay institutions, and should instead be provided with adequate support to live independently within community settings (paragraphs 2.31 –

2.38 of that document refer).

5.3. The Department's review in 1995 of its existing policy in relation to learning disability, *'DHSS (1995) Review of Policy for People with a Learning Disability'* that I have included at MMcG/36 stressed the need for inclusion as the Government policy position for people with a learning disability and integration, not least in the field of health and social services, as a key component of his approach.

5.4. During 2002 the Department commissioned Professor David Bamford to examine the law, policy and provision relating to people with mental health needs or learning disability. The Bamford Review was published over a series of ten reports and was finally completed in 2007.

5.5. The Bamford Review report relating to Learning Disability entitled 'Equal Lives' was the second report from the Review, and was published in 2005. I attach a copy of the report at McMcG/37.

5.6. In October 2005 the Department published 'Care at its Best' – a Report on a Regional Multidisciplinary Inspection of the Service for Disabled Children in Hospital'. I attach a copy of this report at McMcG/38.

5.7. The report summarised the findings of a regional inspection of services for disabled children in hospitals, including Muckamore Abbey Hospital. The aim of the inspection was to assess the extent to which the service for disabled children in hospital met the requirements of the Children Order and reflected standards of best practice in a number of key areas. The report contained 80 recommendations for the Department and the HSC to take forward.

5.8. Also in 2005, the Department published 'A Healthier Future: A 20-year vision for health and well-being in Northern Ireland 2005-2025'. I attach a copy of this at MMcG/30. This document, which set an overall framework for the development of health and social services across

Northern Ireland, acknowledged the work being undertaken by the Bamford Review to examine services for people with a learning disability, and re-stated the policy commitment to support community integration.

5.9. The Department subsequently produced on behalf of the NI Executive two Bamford Action Plans, the first of which covered the period 2009-2011, with the second covering the period 2012-2015. I attach copies of both these Action Plans at MMcG/39 and MMcG/40.

5.10. In 2010, the Department published 'Promoting Quality Care' which set out principles of good practice for individual professionals and organisations on the assessment and management of risk in mental health and learning disability services. The 16 principles of good practice incorporate working with service users, team working, risk management process and communication. I attach a copy of the guidance at MMcG/41.

5.11. The 'Transforming Your Care' report which the Department published in 2011 restated the commitment to ensuring that no one should be required to live in long stay institutions and supporting those with learning disabilities in the community (pp94-97). I have attached a copy of this report at MMcG/42.

5.12. Also in 2011, the Department published 'Quality 2020: A 10-year strategy to protect and improve quality in health and social care in Northern Ireland'. I attach a copy of this strategy at MMcG/43. The document sets a strategic framework and plan of action to protect and improve quality and patient safety across a range of health and social care services.

5.13. In 2012, the Department published an evaluation of the first Bamford Action Plan, and I attach a copy of this at MMcG/44.

5.14. Also in 2012, the Department launched the Service Framework for Learning Disability for implementation. I attach a copy of the Framework at MMcG/33.

5.15. The Framework aimed to improve the health and wellbeing of people with a learning disability and their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.

5.16. Service Frameworks set out clear standards of health and social care that were both evidence based and measurable. They set out the standard of care that service users and their carers should expect, and were also used by health and social care organisations to drive performance improvement through the commissioning process. The Service Framework for Learning Disability built on the approaches to supporting people with a learning disability proposed in the Bamford Review and the first Bamford Action Plan.

5.17. The Service Framework Programme Board decided in 2018 not to renew the Learning Disability Framework. I attach a copy of a letter advising of this decision at MMcG/45.

5.18. Under the terms of its 2006 agreement with NICE, the Department has endorsed for application in Northern Ireland a number of NICE clinical guidelines relevant to the area of learning disability.

5.19. In July 2015, the Department endorsed the NICE Clinical Guideline 'NG11 – Challenging Behaviour and Learning Disabilities' as applicable in Northern Ireland, and in November 2016, the NICE Clinical Guideline 'NG54 – Mental Health problems in people with learning disabilities: prevention, assessment and management' was also endorsed for implementation in Northern Ireland. I attach copies of correspondence to HSC organisations advising of these decisions at MMcG/46, and at

MMcG/47.

5.20. The Department issued guidelines on the arrangements for implementing and monitoring NICE guidance in circular *HSC (SQSD) 13/22: NICE Clinical Guidelines – Process for Endorsement, Implementation, Monitoring and Assurance in Northern Ireland*. I have attached this at MMcG/48.

5.21. In 2016, the Department carried out an evaluation of the second Bamford Action Plan, although this was not formally agreed before the suspension of the NI Executive in 2017.

5.22. In 2018, taking account of the findings from the evaluation of the second Bamford Action Plan and the ten-year vision for transforming health and social care set out in the 2016 report 'Health and Well-Being 2026: Delivering Together', the Department commissioned the HSCB to carry out a review of Adult Learning Disability service provision in Northern Ireland, and to design a new regionally consistent outcomes-based model for Adult Learning Disability services.

5.23. A draft Service Model was submitted to the Department in October 2021 and work to incorporate the Service Model into a wider Learning Disability Strategic Plan is being progressed by the Department. A draft of the Learning Disability Strategic Plan has been submitted for consideration by the Department's Top Management Group. It sets out a body of work that seeks to address pressure points across learning disability services for children and adults. A Task and Finish Group has been established to drive this work forward.

5.24. In response to the findings of 'A Way To Go', the level 3 Serious Adverse Incident review of safeguarding arrangements in the hospital which was completed in December 2018, the Department developed the Muckamore Abbey Hospital HSC Action Plan. I attach a copy of the

original Action Plan at MMcG/49.

5.25. To monitor progress on the Action Plan and provide assurance on the safety of services being provided at the hospital, the Department established the Muckamore Departmental Assurance Group in 2019.

5.26. The Action Plan was updated in 2020 to reflect the recommendations of the Independent Review of Leadership and Governance at the hospital. A copy of the updated Action Plan is attached at MMcG/35.

Section 6: Module 3b (Nursing care delivery model)

6.1. In my evidence on this module, I have interpreted the Nursing Care Delivery Model as relating to the overarching policy and regulatory positions regarding the nursing workforce, and my statement is drafted to reflect this.

6.2 The Department recognised that the Nursing profession had a leading role to play in delivering both the underlying vision and practical implementation of the Bamford Review recommendations, and that the profession shared the strategic vision of mental health and learning disability services in Northern Ireland being largely community-based services that explicitly and demonstrably meet the needs of patients, clients and carers by involving them as equal partners in all aspects of their care.

6.3. Learning disability nursing is based on clear values that include placing individuals at the centre of care and ensuring they are fully involved in all aspects of planning and intervention. It also acknowledges the critical contribution of family and informal carers.

6.4. These values are based on the NMC Standards of Proficiency and NMC Code of Conduct, attached at MMcG/50 and MMcG/51.

6.5. The Central Nursing and Midwifery Advisory Committee is a statutory advisory body established in 1974 under Article 24 of the 1972 Order. Its function is to provide relevant, timely and resolved advice to the Minister and the Chief Nursing Officer (CNO) on matters concerning nursing and midwifery in Northern Ireland.

6.6. The Code of Professional Conduct was published by the Nursing and Midwifery Council in April 2002 and came into effect on 1 June 2002. There have been a number of revisions since this date, and I attach a copy of the current code at MMcG/51. The Nursing and Midwifery Council is the UK Regulator and, nurses and midwifes in Northern Ireland are required adhere to the standards set out in this document.

6.7. In 2002, the Department published the *'Review of the Nursing, Midwifery and Health Visiting Workforce: Final Report'*, with additional review reports published in 2005, updated in 2007, and 2009. These reviews provided a detailed profile of the workforce, including learning disability nurses, identified current issues impacting on the profession and made projections of the supply and demand as well as setting out changes in the workforce from the previous review. I attach a copy of the 2002 report at MMcG/52, and the 2009 report at MMcG/53.

6.8. In 2006 the Department commissioned the Northern Ireland Practice & Education Council for Nursing and Midwifery (NIPEC) to carry out a review of guidance on clinical supervision in the HPSS, to evaluate supervision systems in place at the time, and establish an action plan to ensure that clinical supervision systems were put in place. In December 2006 the *'Report of the Review of Clinical Supervision for Nursing in the HPSS 2006 on behalf of the DHSSPS'* was published. The report indicated that there was limited evidence of widespread implementation of effective systems of clinical supervision across nursing in Northern Ireland and included a number of recommendations to help standardise an approach. I attach a copy of the report at MMcG/54.

6.9. In 2010, the Department published the *'Partnership for Care – Northern Ireland Strategy for Nursing and Midwifery 2010-2015'*. I have attached a copy of this at MMcG/55.

6.10. This strategy presented a high-level road map for nursing and midwifery over a period of five years through a partnership for care. The achievement of this would maximise the effectiveness of the nursing and midwifery contribution to improving health and social wellbeing and tackling inequalities for the population. The strategic themes capture both the enduring values of nursing and midwifery as well a vision for the future. These are relevant to all care settings; including Learning Disability.

6.11. In 2012, the UK Modernising Learning Disabilities Nursing Review was commissioned and led by the Chief Nursing Officer for Scotland on behalf of the chief nursing officers across the UK. The report of the Review, *'Strengthening the Commitment'* was published in 2012 and aimed to set the direction of travel for learning disabilities nursing across the United Kingdom, with a renewed focus on learning disability nursing as a service. I attach a copy of this at MMcG/56.

6.12. In response, the Department launched in 2014 the Northern Ireland action plan to implement the recommendations in '*Strengthening the Commitment'.* The Action Plan was updated in 2016, and I attach a copy of the updated Action Plan at MMcG/57.

6.13. As part of the action plan, a Northern Ireland Learning Disabilities Nursing Collaborative was established in 2014 by the then Chief Nursing Officer in the Department to oversee the delivery of a number of learning disability specific actions. The programme of work is facilitated and supported by the Northern Ireland Practice and Education Council and the Collaborative includes representation from the Independent Sector, all five Health and Social Care Trusts,

Educational Providers and the Public Health Agency. NIPEC have produced a range of reports and updates, published on their website. I attach a copy of the most recent progress report at MMcG/58. Following a decision in 2019 by the UK CNO's to stand down the Strengthening the Commitment Groups, along with the commissioning of a review of the learning disabilities nursing workforce in Northern Ireland around the same time, the Collaborative was re-established in September 2022 as the Registered Nurse Learning Disabilities – Strategic Development Project Group.

6.14. The Department published 'A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2016)' in May 2016. The recommendations contained within the Plan sought to lay the foundation for the development of a competent, confident, critical-thinking and innovative nursing workforce in Northern Ireland. It outlined the requirement for a culture of transparency, openness and a willingness to challenge, to ensure that decisions made resulted in safe, effective, person-centred and compassionate care with improved outcomes and positive patient and client experiences. The Plan also recommended a review of learning disability programmes to help future proof the workforce to ensure they were equipped to manage and provide interventions to those with complex physical and mental health needs. I attach a copy of the Plan at MMcG/59.

6.15. Work was initiated in 2021 to undertake the review of the learning disabilities nursing workforce across NI to include all sectors. The need for continued reflection on the profession and the role of the learning disability nurse is a healthy method of addressing the evolving needs of the learning disability population. With medical and scientific advances, children with learning disabilities are surviving and thriving and people with a learning disability are living longer lives. This had led to the need for a greater integration of people with learning disabilities into the general health services but there also remains the need for specific

healthcare and social care needs that can present with an individual with a learning disability.

6.16. To address these ongoing challenges, work has been commissioned by the CNO to review the role of the learning disability nurse across healthcare trusts to enable people with a learning disability, their families and carers to be supported to achieve and maintain good health and to live long, healthy and happy lives. As a result of this, recommendations will be made that identify the unique skills and expertise required of a learning disability nurse but also recognise the need for the development of professional skills and services to meet the changing health needs of people with learning disabilities across Northern Ireland. The resulting report is due to be published imminently.

6.17. Perhaps the most important driver for change in the profession is the Nursing & Midwifery Task Group (NMTG) report. In 2016, the then Health Minister, Michelle O'Neill established a NMTG independently chaired by Sir Richard Barnett. The core aim of the group was to develop a roadmap that would provide direction in achieving world class nursing and midwifery services in a reconfigured health and social care system over the next 10 - 15 years.

6.18. The group were asked to consider this core aim within the context of developing a population/public health approach and to identify through evidence and innovation how the socio-economic value and contribution of nursing and midwifery could be maximised in order to improve health and social care outcomes. The report was launched by the Minister on March 2020, and sets out an ambitious future agenda for nursing and midwifery which will make a significant contribution to the transformation of health and social care, as set out in the Health and Wellbeing 2026: Delivering Together 2026 Vision. I have attached a copy of this at MMcG/5.

6.19. The Department is working in collaboration with key stakeholders to implement the report's recommendations, with a costed, timebound implementation plan in place to ensure delivery. I attach a copy of the report and its recommendations at MMcG/60.

6.20. The Department operated a Professional Alerts Policy for registered Nursing staff, that I have included at MMcG/61. This policy was revoked in December 2022 and has not been replaced. I have included a copy of the letter to all relevant HSC Bodies confirming this at MMcG/62.

6.21. The Chief Nursing Officer Group (CNOG) within the Department, work with the NMC to influence the setting of standards. Implementation of these standards may either be led by CNOG or employers. The CNO may ask for a review to be undertaken to address specific issues, such the specific review of the learning disabilities nursing workforce as previously referenced in paragraphs 6.15 and 6.16.

Section 7: Module 3c (Policies regarding restraint/seclusion)

7.1. While HSC organisations always strive to keep the use of restrictive practices to an absolute minimum, nevertheless there are times when employing restrictive practice is sometimes necessary in health and social care settings, particularly when protecting individuals from harm.

7.2. This can include, for example, the use of lap belts in wheelchairs to stop the person falling out to prevent injury or using cot sides on beds so fragile people can sleep safely. However, in more serious situations, it can also include the use of physical restraint to prevent or restrict movement, or medication when a person is acting in a way that may cause serious harm to themselves or others. For the most significant cases, this may also include the use of seclusion in a mental health or learning disability hospital setting.

7.3. Restraint and seclusion in relation to the care of service users should only be used in exceptional circumstances and all techniques used must be approved, safe and in compliance with international rights standards.

7.4. Prior to 2003, a lack of specific legislation and guidance resulted in a lack of uniformity of approach across the health and social care sector and no standard threshold indicating when restraint and seclusion could be used legally. A Human Rights Working Group was therefore established by the Department Human Rights Liaison Group in 2003, in recognition of the need to assist Health and Personal Social Services staff and others to ensure that their practice was safe and met human rights requirements.

7.5. This Working Group, which was multi-professional and comprised of members from both the voluntary and statutory sectors, developed a guidance document in August 2005 entitled '*Guidance on Restraint and Seclusion in Health and Personal Social Services'*. In April 2006, the Department issued this guidance to Health and Social Service Boards and Trusts, and any other relevant organisation in the health and social care sector. It commended it as a useful contribution to the development of operational policies and procedures on the use of restraint and seclusion across the Health and Personal Social Services (HPSS) to ensure both service users safety, and the protection of staff. I attach a copy of the Departmental letter along with the associated guidance at MMcG/63 and MMcG/64.

7.6. The guidance was intended to be overarching and to be used to inform at provider level for the development of policies and procedures, training and practice across the relevant client groups in both hospital and residential settings.

7.7. In October 2010 the Department issued formal interim guidance on *'Deprivation of Liberty Safeguards (DOLS)*' to ensure that detentions

amounting to deprivation of liberty were compliant with the European Convention on Human Rights. I attach a copy of this circular at MMcG/65.

7.8. The Mental Capacity Bill passed its Final Stage in the Assembly on 15 March 2016 and received Royal Assent on 9 May to become the Mental Capacity Act (Northern Ireland) 2016 (the 2016 Act). A decision was taken in 2019 by the Department of Health and the Department of Justice, as co-authors of the Bill, to implement the Mental Capacity Act in a phased approach. The deprivation of liberty provisions within the Act commenced on 2 Dec 2019. The Deprivation of Liberty Safeguards (DoLs) provisions (Chapters 1, 2 and 4 of the Mental Capacity Act) provide a legal framework for any required detentions of people aged 16 and over who lack capacity and cannot be detained under the Mental Health (NI) Order 1986. The October 2010 circular I refer to above providing interim guidance on deprivation of liberty was consequently superseded when DoLs came into operation in December 2019.

7.9. A Mental Health Action Plan was published by the Department on 19 May 2020 (with the Action Plan subsequently being superseded by the Mental Health Strategy 2021-2031 published in June 2021). I have included a copy of both of these documents at MMcG/66 and MMcG/67. As part of the Action Plan at action 6.5, the Department committed to review restraint and seclusion, and to develop both a regional policy on restrictive practices and seclusion and also a regional operating procedure for seclusion.

7.10. Further to this, the Department carried out a public consultation on a new '*Regional Policy on the use of Restrictive Practices in Health and Social Care settings*' which closed in October 2021. The purpose of the regional policy is to provide a regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion, across all areas where health and social care is delivered in

Northern Ireland. The consultation report and revised policy were subsequently approved by the then Minister of Health in October 2022. The Department is currently completing its final check of the policy and plans to share both documents with key stakeholders before they are published online in 2023.

Section 8: Module 3d (Safeguarding policies)

8.1. The purpose of Departmental Safeguarding legislation, policy and guidance is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect for the purpose of reducing the prevalence of harm. It is to help ensure support is available to adults at risk, and that effective protective interventions are provided. It places significant emphasis on prevention and early intervention. It also seeks to ensure that access to justice is available to adults that have been harmed.

8.2. Since 1999, there have been a number of changes in the Department's guidance on adult safeguarding, and in particular a move to focus on an individual human rights led approach with the patient at the centre.

8.3. In June1999 there was no legislation specific to safeguarding in Northern Ireland. Safeguarding practice largely drew on other pieces of legislation at this time, including the 1972 Order (Article 37 permitting the removal to suitable premises of persons in need of care and attention), the Criminal Law Act (Northern Ireland) 1967 (which established an obligation on citizens, if they suspect a serious offence had been committed, to provide the police with any information they may have which is likely to help to secure the arrest, prosecution or conviction of a suspect), and the Mental Health (NI) Order 1986 (Article 121 provides for an offence of ill treatment or wilful neglect of someone in hospital or a nursing home who is being treated for a mental disorder).

8.4. In 2002, the Department supported the establishment of a Regional Adult Protection Forum to promote, develop and improve arrangements for the protection of vulnerable adults. Through the Forum's work it became increasingly clear that effecting further significant progress in safeguarding arrangements lay in the production of regional policy and procedures. This was reinforced by the degree of organisational change which was being proposed at that time by the Review of Public Administration in Northern Ireland.

8.5. In December 2003, the first version of a '*Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults'* was published. I attach this at MMcG/68.

8.6. This Protocol set out the roles and responsibilities of respective agencies and provided guidance about joint working arrangements and investigation. The Protocol was developed in partnership between the Department, the PSNI, Health and Social Care Boards and Trusts, and built on guidance which had been issued by the Department in 1996 as the basis for the development of Board and Trust adult protection policies. I have not to date been able to source a copy of this guidance.

8.7. The Protocol was underpinned by local research and took cognisance of guidance issued in Great Britain by the Home Office and Department of Health in England. It set out a framework for joint working in this complex area of practice and emphasised the need to involve all relevant agencies in information sharing, early assessment and the planning process. In 2005, the Regional Adult Protection Forum received Departmental endorsement to produce standardised regional procedures for the protection of vulnerable adults, and in 2006, the Department published *''Safeguarding Vulnerable Adults', a Regional Adult Protection Policy and Procedural Guidance'*. A copy of this is included at MMcG/69.

8.8. This document detailed the processes to be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect. The purpose of developing regional procedural guidance for Northern Ireland was to ensure a co-ordinated and standardised approach by all those working with vulnerable adults and to establish the principles of good practice in this area of work. This guidance was derived from best practice in Northern Ireland and with reference to developments elsewhere in the UK.

8.9. Following this, in July 2009, '*the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults'* was published. I attach a copy of this at MMcG/70. It was developed in partnership between the Department, the PSNI, the Regulation and Quality Improvement Authority (RQIA), the Health and Social Care Trusts and the former Health and Social Services Boards.

8.10. It recognised the need for more co-ordinated interagency working to ensure that vulnerable adults, who are at risk of abuse, receive protection, support and equitable access to the criminal justice system. The Protocol outlined the roles and responsibilities of the respective agencies and provided guidance about joint working arrangements and investigation.

8.11. In 2009, the Department working with the Northern Ireland Office (NIO) and with the support of other government departments, issued a paper for consultation, *'Reforming Northern Ireland's Adult Protection Infrastructure'*. Following analysis of the consultation responses, the Department and the Northern Ireland Office issued in 2010 a joint guidance document*, 'Adult Safeguarding in Northern Ireland - Regional and Local Partnership Arrangements'*. I attach a copy of this document at MMcG/71.

8.12. This guidance established the Northern Ireland Adult Safeguarding Partnership and five Local Adult Safeguarding Partnerships. These

were collaborative partnerships with a responsibility for adult safeguarding in Northern Ireland, and replaced the Regional Adult Protection Forum. The Partnerships were tasked with the delivery of improving adult safeguarding outcomes by way of a strategic plan, operational policies, procedures and effective practice, which were developed and implemented in accordance with policy.

8.13. In April 2011 the Department commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and learning disability hospitals across the five HSC Trusts in Northern Ireland.

8.14. RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into a planned program of inspections for 2011-2012. The report of these inspections in 2013 summarized the findings from 33 inspections carried out between December 2011 and July 2012, and contained 2 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults. A follow-up report was published in 2015.

8.15. The Northern Ireland Executive identified Safeguarding adults at risk as a priority in their Programme for Government 2011-2015. In response, the Department in partnership with the Department of Justice developed and published further guidance, *'Adult Safeguarding Prevention and Protection in Partnership'*, in July 2015. I attach a copy of this document at MMcG/72.This replaced the 2006 guidance referenced earlier in this statement.

8.16. The aim of the policy was to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. It set out how the Northern Ireland Executive intended adult safeguarding to be taken forward across all Government Departments, their agencies and in partnership with voluntary, community, independent and faith

organisations. A key objective was to reduce the incidence of harm from abuse, exploitation or neglect of adults who are at risk in Northern Ireland; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families.

8.17. In August 2016, the 'Protocol for Joint Investigation of Adult Safeguarding Cases', was published, and this is included at MMcG/73. This was the third edition of the Joint Protocol and replaced the 2009 Protocol I referenced earlier at paragraph 8.3.

8.18. The aim of the Joint Protocol was to ensure that adults in need of protection were supported in a manner which upheld their rights, in particular their right to equal access to the criminal justice system and to prevent abuse through a collaborative multi-agency partnership.

8.19. Following the widely publicised safeguarding failings at Muckamore Abbey Hospital and Dunmurry Manor Care Home which highlighted the need to review and improve Adult Safeguarding policy in Northern Ireland, the then Minister for Health announced in 2020 the launch of a public consultation on a range of legislative options on safeguarding.

8.20. The consultation closed in April 2021, and following analysis of responses, the Department is progressing work to introduce an Adult Protection Bill which will provide a statutory underpinning for safeguarding arrangements in Northern Ireland.

8.21. It is worth noting that the draft Adult Protection Bill will need to be cleared by the Health Minister, and then by the Executive, before being introduced to the Northern Ireland Assembly, therefore the draft Bill cannot be introduced until an Executive is formed.

Section 9: Module 3e (Policies and procedures re medication / auditing of medication)

9.1. The Department recognises the vital role medicines play in maintaining wellbeing, preventing illness and managing disease. Medicines are the most common medical intervention within our population and at any one time 70% of the population is taking prescribed or over the counter medicines to treat or prevent ill-health. Expenditure on medicines equates to over £700m per annum in Northern Ireland, representing a significant share of the total Health and Social Care (HSC) budget and is the second largest single cost after salaries.

9.2. Over the period from 1999 to 2021, there have been a number of statutes in place to ensure the safe regulation of medicines. The Medicines Act was introduced in 1968, and provides a legal framework for the prescribing, supply, storage and administration of medication.

9.3. The Human Medicines Regulations set out regulations for the authorisation of medicinal products for human use, for manufacture import, distribution and the sale and supply of products.

9.4 The Misuse of Drugs Act 1971 came into effect in 1973 and its main purpose was to prevent the misuse of controlled drugs and achieved this by imposing a complete ban on the possession, supply, manufacture, import and export of controlled drugs except as allowed by regulations or by licence from the Secretary of State or in Northern Ireland, the Department of Health.

9.5 Following this, the Misuse of Drugs (Northern Ireland) Regulations 2002 came into force in February 2002.These Regulations relax various prohibitions from the Misuse of Drugs Act 1971 to allow doctors, dentists, veterinary practitioners and veterinary surgeons when acting in their professional capacity to prescribe, administer, manufacture, compound or supply a controlled drug, as well as pharmacists and persons lawfully conducting a retail pharmacist business to manufacture, compound or supply a controlled drug.

9.6 Using powers within the UK-wide Health Act 2006, he Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 were enacted by the Department to improve controlled drug governance without hindering patient access to the treatment they needed. These were amended in 2015 by the Controlled Drugs (Supervision of Management and Use) (Amendment) Regulations (Northern Ireland) 2015 which came into operation in July 2015. In this legislation additional requirements were specified for Accountable Officers, including introducing more flexibility for appointing an Accountable Officer, and extending the meaning of a relevant person, as well as specification that the responsibility for the Local Intelligence Network became the responsibility of the then HSCB's Accountable Officer.

9.7 In August 2012, the UK government consolidated medicines legislation, including the Medicines Act 1968 into one set of new regulations, known as the Human Medicines Regulations 2012. Some parts of the Medicines Act 1968 are still in force.

9.8 The Department first published '*Use and Control of medicines'* in 1999 which provided guidelines for Health and Personal Social Services organisations on the safe prescribing, administration, handling, storage and custody of medicines which were updated in 2004. I have to date been unable to locate a copy of the 1999 guidance, and I attach a copy of the updated guidelines at MMcG/74. In 2013 the Chief Pharmaceutical Officer advised HSC Heads of Pharmacy and Medicines Management that no further editions of the guidance would be published. I attach a copy of the letter at MMcG/75.

9.9 In 2005, the Department's Chief Pharmaceutical Officer endorsed for application in Northern Ireland guidance developed by the Royal Pharmaceutical Society of Great Britain, 'The Safe and Secure Handling of Medicines: A Team Approach', which updated the 1988

Duthie Report to reflect changes in legislation and developments in practice. I attach a copy of this guidance at MMcG/76.

9.10 In 2003-04, the Department introduced Controls Assurance Standards to Health and Social Care organisations. The Controls Assurance process aimed to provide evidence that Health and Social Care bodies were taking reasonable steps to manage themselves in meeting their objectives to protect patients, staff, public and other stakeholders against risks of all kinds. There were 22 Controls Assurance Standards in total, one of which related to Medicines Management. I attach the Medicines Management Controls Assurance standard from 2014 at MMcG/77.

9.11 Each Standard comprised a number of individual criteria which brought together all of the statutory obligations, as outlined in medicines legislation including the Medicines Act 1968, Human Medicines Regulations 2012, and Misuse of Drugs Regulations (Northern Ireland) 2002, as well as Departmental guidance, and professional requirements in the field concerned. The Medicines Management Standard required assurance to be provided at a corporate level by HSC Chief Executives to DoH Governance Unit on the use and control of medicines within the organisation, and the verification process for this assurance included requirements for policies, procedures and audit.

9.12 Following a review of the whole Controls Assurance process, the Department wrote to HSC organisations in 2018 advising of the introduction of revised assurance arrangements, which included new and proportionate alternative assurance arrangements for medicines management. These focused on development of a more streamlined standard focused on the extant responsibilities of HSC organisations to oversee delivery of Medicines Codes / Policies that support safe, effective practice and compliance with relevant legislation. I attach a copy of this correspondence at MMcG/78 and a copy of the Update

Summary at MMcG/79. I also attach further correspondence from the Chief Pharmaceutical Officer at MMcG/80.

9.13 The Department established formal links with the National Institute for Health and Care Excellence (NICE) on 1 July 2006 whereby guidance published by the Institute from that date would be locally reviewed for applicability to Northern Ireland and, where appropriate, endorsed for implementation in HSC. This link has ensured that Northern Ireland has had access to up-to-date, independent, professional, evidence-based guidance on the value of health care interventions including clinical guidelines relating to the identification and assessment of mental health problems in adults and those with learning difficulties as well as the development of effective local care pathways.

9.14 In 2006, the Department published *'The Quality Standards for Health and Social Care'*, which set out the standards the Department considered people should expect from Health and Personal Social Services. I attach a copy of the Standards at MMcG/81 and would draw the Panel's attention to paragraph 5.3.1(f), which sets out the requirements for systems, policies and procedures in relation to medicines management. that ensure safe practice in the selection, procurement, prescription, supply, dispensing, storage and administration of medicines across the spectrum of care provided, in compliance with medicines legislation. The Quality Standards are used by RQIA to assess the quality of care provided.

9.15 The Department has also published a number of guidance documents on the safe management and use of controlled drugs, as set out below.

9.16 *'The Safer Management of Controlled Drugs - A guide to good practice in secondary care (Northern Ireland)*' was first published in August 2009 and revised in August 2012. I attach a copy of the 2012 guidance at MMcG/82.

9.17 Further guidance on Standard Operating procedures for Controlled Drugs was published in 2009, with a copy attached at MMcG/83 and guidance on strengthened governance arrangements for controlled drugs was published in 2015. I attach a copy of this at MMcG/84.

9.18 Clinical pharmacy is an integral part of medicines management. In 2013 Northern Ireland Clinical Pharmacy Standards were developed by the five HSC Trust Heads of Pharmacy and Medicines Management, with the aim of improving the clinical pharmacy contribution to patient care by developing a structured, systematic approach to clinical pharmacy practice. These guidelines were not developed by the Department but were hosted on the Department's website.

9.19 In 2016, the Department published a Northern Ireland Medicines Optimisation Quality Framework. I attach a copy of this at MMcG/85.

9.20 The Framework's aim was to support better health and wellbeing for all people in Northern Ireland through improvements in the appropriate safe and effective use of medicines. It set the strategic direction for improvement in the use of medicines across the HSC across four areas focussed on medicines safety, innovation, workforce and efficiencies. The Framework promoted multidisciplinary working with the integration of pharmacists helping patients gain the best possible outcome from their medicines every time that they were prescribed, dispensed or administered.

9.21 In 2020, the Department published *'Transforming medication safety in Northern Ireland'.* This five-year plan was produced collaboratively with healthcare professionals and service users from across Northern Ireland in response to the World Health Organisation's Third Global Patient Safety Challenge 'Medication without Harm'. I attach a copy of this at MMcG/86.

9.22 The Department issued correspondence in 2021 seeking support for cost effective prescribing policy to be embedded across the HSC. I have included a copy of this at MMcG/87.

9.23 The achievement of safe, clinically effective and cost-effective prescribing and medicines supply is in the interests of all patients and healthcare practitioners. Strategies to achieve this can improve outcomes for patients by reducing harm, improving adherence to medicines and freeing up resources to treat more patients. The Department's policy statement on implementation of medicines optimisation & cost-effective prescribing and supply of medicines outlines the approaches to be adopted across the HSC to support this aim including medication review, medicines reconciliation, development of arrangements and systems to ensure evidence based, safe and cost-effective prescribing, and collaborative working arrangements. I attach a copy of this document at MMcG/88.

9.24 In respect of arrangements for audit the Department has not provided specific processes for auditing medication use, as professionals are already trained on how to undertake audits as part of their professional education and development and so such direction from the Department would be unnecessary. Trusts develop their own processes for the circumstances for auditing use of medicines in line with their own medicines governance codes and policies.

Section 10: Module 3g (Policies and procedures re psychological treatment, speech and language therapy, occupational therapy and physiotherapy)

10.1. Allied Health Professionals (AHPs) are a diverse group of clinicians who work in a range of disciplines to deliver treatment and care to service users across a wide range of services in a variety of different settings and across all age groups. This includes those who provide psychological treatment, speech and language therapy, occupational therapy and physiotherapy.

10.2. The policy of the Department has been to promote the provision of a wider range of services in the community and facilitate the shift away from dependence on hospital services as set out in *'People First'* (MMcG/3). The role of many AHPs has changed to reflect this with more services provided by AHPs as part of multi-disciplinary teams working in the community.

10.3. In 2012 the Department launched *'Improving Health and Well-being Through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland 2012-2017'.* I attach a copy of this document at MMcG/89. I have not been able to identify records of any relevant policies or strategy relating to Allied Health Professional practice prior to this Strategy.

10.4. This Strategy set out a high-level road map for the development of the AHP workforce and to support the commissioning and delivery of AHP practices to enhance the health and social well-being of the population in Northern Ireland.

10.5. Given the diversity of the AHP disciplines and the wide-ranging nature of AHP practices, the Strategy did not seek to address in detail what services are provided to service users or how they are delivered. Instead, it focused on the approach to care outlining how, by implementing key actions at strategic, organisational and individual levels, the AHP workforce can meet the challenges of planning and delivering high quality services that are person-centered, safe, fit for purpose and provide good value for money.

10.6. A further strategic framework and the first UK-wide AHP Public Health document, *'UK Allied Health Professions Health Strategic Framework 2019-2024'* was published in 2019. The Department was jointly involved in producing this document and I attach a copy of this at MMcG/90.

10.7. This strategic framework sets out the vision for the role of AHPs in public health over five years, along with the goals to achieve its vision. It is intended to help AHPs, as well as their professional bodies and partner organisations, to further develop their role in public health, share best practice with colleagues and partners and ultimately embed preventative healthcare across all of their work.

10.8. In relation to psychological treatment, in 2009 the Department launched a strategy for the development of psychological therapy services. I attach this at MMcG/91. I have not been able to identify records of any relevant policies or strategy relating to psychological treatment prior to this.

10.9. Its overarching aim was to improve the health and social wellbeing of the population of the Northern Ireland by improving access to psychological therapies and by being more responsive to service user's needs.

10.10. Following a review of Speech and Language Therapy services by the Northern Ireland Commissioner for Children and Young People, the Department published in 2011 the *'Speech, Language and Communication Therapy Action Plan: Improving Services for Children and Young People (2011/12 – 2012/13)'*, and I attach a copy of this at MMcG/92.

10.11. The aim of the Action Plan was that all children and young people at risk of or presenting with speech, language or communication needs will be able to benefit from timely support and integrated services that best meet their requirements.

Section 11: Module 3h (Resettlement policies (and provision for monitoring of resettlement)

11.1. Since the early 1990's, the overarching policy direction of the Department has been the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey to community living facilities, in line with the broad framework for the development of community care services in Northern Ireland for vulnerable people set out in *'People First*' (MMcG/3).

11.2. In or around 1995, the Department published a report of a review of its existing policy for people with a learning disability '*Services for the Mentally Handicapped in Northern Ireland – Policy and Objectives' (the 1978 Statement)* which had been published in 1978.

11.3. I attach a copy of the review's report, *'Review of Policy for People with a Learning Disability'*, at MMcG/36. The report set the agenda for the development of policy for people with a learning disability into the 21st century, and among other things concluded that *'the aim of Government policy for people with a Learning Disability should be inclusion'* (para 9.25) and also that *'resettlement of those in hospital should be pursued with the utmost vigour as a primary objective (para 9.26)'.*

11.4. In or around 1995, the Department took a decision that it would seek to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland within accommodation offering a better life for the patient. The defining principle was that resettlement should be offered where it is clinically appropriate, meets the patient's needs, has the potential to better the life of the patient and is in line with the wishes of the patient and their family, where this is appropriate. These criteria are addressed under the heading of 'betterment'.

11.5. The term 'betterment' emerged in the mid-1990s when conflict arose between those charged with delivering the resettlement programme at that time, and families who sometimes felt that their family member would be better off in hospital. In 1995, the Northern Ireland Minister of

Health at the time gave a public assurance to families that a member of their family living in hospital would only be resettled into the community if there was clear evidence of betterment for the patient and provided that it was not against their wishes. This commitment has been restated by successive Ministers and remains in place, and was a key principle underpinning the Bamford vision.

11.6. In 1996 the Department issued *'Health and Well-being into the next Millennium'*, setting out a five-year regional strategy for health. I attach a copy of the strategy at MMcG/93.

11.7. The Strategy (paragraph 10.4; p86) required HSS Boards and Trusts to develop a comprehensive range of support services by 2002, with a commitment that long term institutional care should not be provided in traditional specialist hospital environments and the number of adults admitted to specialist hospitals should reduce.

11.8. In 1999, the Department established a Regional Project Steering group to provide direction and oversee the resettlement process. The Group was made up of representatives from the Department, the four Health Boards and the North and West Belfast Trust, which had responsibility at that time for the management of Muckamore Abbey Hospital. This Steering Group remained in operation up until the Department commissioned the Bamford review in 2002.

11.9. In 2000, the Department commissioned a review of the provision of care in the community. The review provided an overview on how community care reforms were progressing. These reforms included the then Boards and Trusts taking on new responsibilities for assessing health and social care needs and funding residential and nursing home placements. I attach a copy of this review at MMcG/94.

11.10. A further review also took place in 2002 and I attach a copy of the report at MMcG/95.

11.11. The original target in the Strategy for the resettlement of all long-stay patients from learning disability hospitals was 2002. However, by that time, only half of patients had been resettled and none of the three hospitals had been closed to long-stay patients. Between 1992 and 2002 the number of long-stay patients in such facilities dropped from 878 to 453.

11.12. The *'Equal Lives'* report of the Bamford Review in 2005 included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. For the purposes of monitoring progress towards this commitment to resettlement, individuals who had been living in a long stay Learning Disability hospital for more than a year as of 1 April 2007 were defined as Primary Target List patients, with progress on delivery of resettlement targets measured by reference to this identified group of individuals.

11.13. In 2007, the Minister with responsibility for the Department, Paul Goggins MP, published an Action Plan which re-asserted the importance placed on the resettlement programme. I attach a copy of the associated Departmental press release announcing this at MMcG/96.

11.14. To oversee progress on the Health Minister's Action Plan, the Department established a Regional Resettlement Team. This Team had representation from all major stakeholders in the resettlement programme, including service commissioners, Trust and hospital staff, representatives from the then Department for Social Development, the Northern Ireland Housing Executive, voluntary and community sectors and the Society of Friends of Muckamore. I attach a copy of the Terms of Reference of this Team at MMcG/97.

11.15. The Department set targets for HSC Trusts relating to the timely resettlement of learning disability patients on an annual basis through the Department's priority setting process.

11.16. As an example of this, I attach *'Priorities for Action 2007-2008'* at MMcG/98, in which the Department set a target for the resettlement of 90 patients from mental health and learning disability hospitals by March 2008, and also allocated additional funding to deliver on this.

11.17. As a further example, I have attached the '*Commissioning Plan Direction 2012'* at MMcG/9 and would draw the panel's attention to Target 28. Copies of the Department's priority setting documents for other years with the associated resettlement targets can be provided to the Inquiry as required.

11.18. The Department monitored progress on the resettlement targets set in the Commissioning Plan Direction in line with the performance management and service improvement arrangements set out in the Framework Document (paragraphs 6.28-6.39).

11.19. An inter-Departmental Ministerial Group chaired by the Health Minister was established in 2007 to oversee the Government response to the recommendations arising from the Bamford Review, including the actions on resettlement. The Group had representation from all Departments charged with responsibility to deliver actions within the Bamford Action Plan. These included the Department of Education, the Department for Employment and Learning (now dissolved), the Department for Social Development (now the Department for Communities), the Department for Regional Development (now the Department for Infrastructure), the Department of Culture, Arts and Leisure (now dissolved), the Office of the First Minister and the Deputy First Minister (now the Executive Office), the Department of Enterprise, Trade and Industry (now the Department for the Economy), and the Department of Justice. The Ministerial Group was supported by an

Inter-Departmental Senior Officials Group.

11.20. *'Transforming Your Care'* in 2011 (MMcG/42) restated the commitment to closing long-stay institutions and completing the resettlement programme by 2015.

11.21. The evaluation published in 2012 of the first Bamford Action Plan 2009-2011 noted (MMcG/44, p72 refers) that the resettlement target for learning disability patients has been achieved.

11.22. The evaluation of the second Bamford Action Plan 2012 - 2015 was completed in 2017 and noted that the resettlement programme was almost complete, indicating that of the 347 long stay patients on the Primary Target list in Learning Disability hospital in 2007, only 25 remained in long stay institutions in 2016.

11.23. In December 2018, in response to the findings of the 'A Way to Go' report, the Department's then Permanent Secretary made two further commitments on resettlement. The first of these was that he expected completion of the Bamford resettlement programme by December 2019, and secondly that no-one should call a hospital their home in the future. I attach a copy of the Permanent Secretary's statement at MMcG/99.

11.24. In response, the Department developed the *Muckamore Abbey Hospital HSC Action Plan* (MMcG/35), which includes actions specifically related to resettlement. Performance against all the actions is monitored by the Muckamore Departmental Assurance Group which was established in August 2019 to oversee implementation of the Action Plan. Minutes from the Group have been published on the Department's website since September 2020.

11.25. The Assurance Group also oversaw the work of the Regional Learning Disability Operational Delivery Group, which was established in 2019

as part of the response to the *Muckamore Abbey Hospital HSC Action Plan* to provide the Department with assurance regarding the HSC's actions following 'A Way to Go', to provide oversight of the Permanent Secretary's commitments on resettlement made in December 2018 and to ensure that the development of enhanced and regionally consistent community services for people with a learning disability and their carers are designed to support and sustain people in their communities and avoid the need for inappropriate inpatient admission.

11.26. The Operational Delivery Group was chaired by the then HSCB and had a membership drawn from the Department, all 5 HSC Trusts and other stakeholders including the Department for Communities, the NI Housing Executive and a carer representative. The Group was established in September 2019 to facilitate a co-ordinated regional approach to the resettlement programme.

11.27. Finally on resettlement, the Department commissioned an Independent Review of the Learning Disability Resettlement Programme in 2021, and in response to the Review's recommendations has established a Regional Resettlement Taskforce led by Dr Patricia Donnelly to expedite the resettlement of the remaining delayed discharge patients in Muckamore. The Taskforce took over the role of and replaced in October 2022 the Regional Learning Disability Operational Delivery Group mentioned previously, and reports directly to the Department's Permanent Secretary on progress towards achieving this aim. It draws on good practice learning from successful placements to expedite resettlement arrangements for the remaining patients.

Section 12: Module 3i: (Complaints and whistleblowing: policies and procedures)

12.1. Effective complaints handling is an important aspect of clinical and social care governance arrangements and, as such, will help organisations to continue to improve the quality of their services and

safeguard high standards of care and treatment.

12.2. Similarly, encouraging staff to openly raise concerns in the public interest (or "whistleblowing") as part of normal day-to-day practice is an important part of improving the quality of services and patient safety.

Complaints

12.3. Departmental policy on HSC complaints has been the subject of regular and consistent periods of review, policy implementation, further evaluation and review in the context of emerging best practice. While some of this work pre-dates the Inquiry's Terms of Reference, I would draw the Panel's attention to the Department's guidance on handling complaints in Health and Personal Social Services produced in 1996, which set out detailed arrangements to be implemented by all HPSS Boards and Trusts. I attach a copy of this guidance at MMcG/100.

12.4. The guidance was intended to complement Directions introduced in April 1996 under the Health and Personal Social Services Complaints Procedures Directions (Northern Ireland) 1996, and Regulations which were also introduced in 1996 to provide the statutory and mandatory framework of the Complaints Procedures. I attach copies of the Directions and Regulations as follows:

- MMcG/101 Directions to Health and Social Services Boards on Procedures for Dealing with Complaints about Family Health Services Practitioners 1996;
- MMcG/102 Directions to Health and Social Services Trusts and Boards on HPSS Complaints Procedures 1996;
- MMcG/103 Directions to Health and Social Services Boards on Miscellaneous Matters Concerning Complaints 1996;
- MMcG/104 The General Medical and Pharmaceutical Services (Amendment) Regulations (Northern Ireland)1996;
- MMcG/105 The General Dental Services (Amendment) Regulations (Northern Ireland) 1996;

- MMcG/106 The General Ophthalmic Services (Amendment) Regulations (Northern Ireland) 1996 and
- MMcG/107 The Health and Personal Social Services (Fundholding Practices) Amendment Regulations (Northern Ireland) 1996.

12.5. These complaints procedures were designed primarily for complaints from patients and clients. In February 1996, a circular issued a document *'Guidance for Staff on relations with the Public and the Media'* MMcG/108. It was designed to encourage a climate of openness and dialogue within the HPSS so that staff could freely express their concerns to their managers as a means of contributing to the improvement of services.

12.6. In April 2000, the Department issued *'Guidance on Handling HPSS Complaints: Hospital & Community Health & Social Services'*, which dealt with complaints about hospital and community health and social services. I attach a copy of this guidance at MMcG/109.

12.7. Following a two-year national review of the NHS Complaints Procedure in 1999 – 2000, each UK jurisdiction agreed to review their Complaints procedure.

12.8. During 2002, as part of its wider quality agenda, the Department embarked on a review of the HPSS Complaints Procedure. This saw the start of a lengthy review of all the HPSS Complaints Procedures, and a Regional Complaints Review Group was established to take this forward.

12.9. The Southern Area Complaints Forum, on behalf of the Department, conducted a best practice review of complaints management within the Health and Personal Social Services. Their report was published in 2003, and set out the findings of the review along with best practice principles for future complaints management which were integrated into

subsequent policy. I attach a copy of this report at MMcG/110.

12.10. A consultation on *'Complaints in the HPSS'*, which detailed new proposals for the handling and consideration of HPSS complaints, was carried out in 2007. Following this, in April 2009 the Department issued a new complaints procedure for the HSC, *'Complaints in HSC: Standards and Guidelines for Resolution and Learning'*. A copy of this is at MMcG/111.

12.11. This replaced the 1996 guidance, and provided a unified and streamlined complaints procedure which applied equally to all HSC organisations, including Family Practitioner Services. As such, it was designed to provide a simple, consistent approach for staff handling complaints and for complainants in raising complaints across all health and social care services.

12.12. In 2011 the Department established the HSC Complaints Policy Liaison Group. The aim of the group was to provide a forum that brought together all those HSC organisations involved in the implementation of the HSC Complaints Procedure, to facilitate sharing of information, the identification of issues relevant to policy implementation and to address issues relevant to policy development including advising on policy evaluation.

12.13. In 2019, the Department published revised guidance on the health and social care complaints procedure, which replaced the 2009 guidance. I attach a copy of this revised guidance at MMcG/112.

12.14. The key principles remained unchanged however the revised document followed a refresh of the HSC Complaints Procedure in order to bring it up to date. The guidance came into effect on 1 April 2019.

12.15. As part of the work to facilitate the migration of the HSC Board to the Department, the 2019 guidance was amended and re-issued in 2022 to

reflect the transfer of the HSC Board functions in respect of HSC Complaints to the Strategic Planning and Performance Group in the Department.

Whistleblowing

12.16. In relation to whistleblowing, the Public Interest Disclosure (Northern Ireland) Order 1998 (PIDO) sets out the legislative basis for those workers who raise concerns about wrongdoing and makes provision about the kinds of disclosures that may be protected, the circumstances in which such disclosures are protected and the persons who may be protected. The PIDO allows a worker to breach their duty as regards confidentiality towards their employer for the purpose of 'whistleblowing'. It was introduced in the interest of the public and to protect workers from detrimental treatment or victimisation from their employer if they raise a genuine concern, whether it is a risk to patients, financial malpractice, or other wrongdoing.

12.17. In October 1999, the PIDO became law. The Department issued a circular to the HPSS to draw attention to this legislation. I attach a copy of the circular at MMcG/113. These whistleblowing arrangements provided for staff to be able to raise concerns about health and social care matters without fear of victimisation, and required all HPSS organisations to have local policies and procedures in place to give effect to these arrangements.

12.18. On 17 February 2009, the Department issued a circular providing whistleblowing guidance for HSC organisations, setting out their responsibilities and providing a model policy template for all organisations to adapt to their own circumstances. I attach a copy of this circular at MMcG/114.

12.19. The circular stated that organisations should have clear arrangements in place to assist staff with reporting concerns. If these were not in place, the circular required organisations to take steps to devise and

implement them in line with the model policy template.

12.20. In March 2012, the then Minister for Health, Edwin Poots, wrote to the Chief Executives of all HSC bodies, setting out a number of principles that every employee should expect in relation to raising concerns within their own organisation, which included the right to whistle blow, the right to be heard by management and a responsibility to speak up. I attach a copy of the Minister's letter at MMcG/115.

12.21. The letter encouraged staff to raise genuine concerns where appropriate and emphasised that this was a vital element of good public service based on the values and principles that are at the heart of Health and Social Care.

12.22. In December 2014, the Department commissioned Sir Liam Donaldson to carry out a review of the arrangements for assuring and improving the quality and safety of care in Northern Ireland. His report, *'The Right Time, The Right Place'*, included a recommendation that "the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister".

12.23. In August 2015, the Department commissioned RQIA to undertake a review of the operation of HSC whistleblowing arrangements. The review was published in September 2016 and made 11 recommendations to strengthen arrangements for raising concerns within HSC organisations.

12.24. In response, the Department developed a HSC Whistleblowing Framework and Model Policy. A copy of this policy is at MMcG/116.

12.25. The aim of the Framework and Model Policy was to ensure that under the terms of the Public Interest Disclosure (Northern Ireland) Order 1998 a member of staff was able to raise legitimate concerns when they believe that a person's health may be endangered or have

concerns about systematic failure, malpractice, misconduct or illegal practice without fear of retribution and/or detriment. It was intended to improve accountability and good governance within organisations by assuring the workforce that it is safe to raise their concerns.

12.26. The Regional Whistleblowing Working Group, headed up by Trusts and with Departmental involvement, has recently conducted work in re - drafting the HSC Whistleblowing Framework and Model Policy to ensure it is in compliance with recent good practice guidance. The public consultation in relation to this document finished in September 2022 and the framework and policy is currently being finalised.

Section 13: Module 3j (Overview of mechanisms for identifying and responding to concerns)

13.1. Ensuring the safety and quality of services has long been a key priority for the Department. The HPSS Complaints Procedure (MMcG/100) outlined in the previous section, enabled staff and service users to raise any concerns, and following investigation, receive a response or explanation addressing those concerns.

13.2. As part of the ongoing drive to continually improve services, the Department published 'Best Practice, Best Care' in 2001 which set out a framework for setting standards, including links with the National Institute for Health and Care Excellence and the Social Care Institute for Excellence (para 3 refers). Areas covered included improving clinical governance (para's 5.3 – 5.8 refer), improving regulation of the workforce (para's 6.1 – 6.9 refer), introducing a Duty of Quality (para's 5.9 – 5.11 refer), and establishing what became the Regulation and Quality Improvement Authority (RQIA) (para's 6.10 – 7.8 refer). I attach a copy of *'Best Practice, Best Care'* at MMcG/117.

13.3. Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003

Order) introduced a statutory duty of quality on HSC Boards and HSC Trusts to "put and keep in place arrangements for the purpose of monitoring and improving the quality of health and personal services which it provided to individuals; and the environment in which it provides them", in other words, a system of clinical and social care governance.

13.4. In 2003, the Department issued a circular to HSC organisations on *'Governance in the HPSS – Clinical and Social Care Governance: Guidelines for Implementation'*, requiring the development and implementation of clinical and social care governance arrangements in their organisations. I attach a copy of the circular at MMcG/118.

13.5. In 2004, the Department issued a circular providing interim guidance on the need for the Department to be informed immediately about incidents regarded as serious, provided a definition of what constitutes a serious adverse incident and advised that the Department would collate information on incidents reported to it and provide relevant analysis to the Health and Personal Social Services (HPSS) organisations and agencies. I attach a copy of this circular at MMcG/119.

13.6. As I have previously outlined in module 3(e), in 2003-04 the Department also introduced the system of Controls Assurance Standards to Health and Social Care organisations.

13.7. The Department appointed a Clinical and Social Care Governance Support Team in 2004. This team was tasked with supporting and encouraging implementation of the statutory duty of quality across the HPSS and produced 'Social Care Governance: A Practice Workbook in 2007 and a subsequent 2nd edition in 2013. I have been unable to find a copy of the 2007 guidance, and will continue to search for this, and I attach a copy of the 2nd edition at MMcG/120. From 1 September 2008 the Support Team became the new HSC Safety Forum to proactively

support the promotion of a safety culture in health and social care across Northern Ireland. I attach a copy of the Department's letter to its arms-length bodies advising of the establishment of the new HSC Safety Forum at MMcG/121. The Safety Forum produced a 2009-2010 annual report outlining collaboratives being held and support on specific areas being provided to Trusts I have included a copy of this at MMcG/122. From April 2009, following the establishment of the HSC Quality Improvement forum (HSCQI), the HSC Safety Forum was incorporated into that new structure.

13.8. Following the introduction of the 2003 Order, and specifically Article 3 of the Order, the new independent HPSS Regulation and Quality Improvement Authority was established and formally came into existence in April 2005. Under Articles 4 and 5 of the 2003 Order, it has an important role in relation to the inspection and investigation of the performance in HPSS organisations (Health and Social Services Boards, Health and Social Services Trusts and special agencies) and reporting on their findings to the Department.

13.9. The Department issued further circulars setting out arrangements for managing Serious Adverse Incident reporting in June 2005 and in March 2006. These circulars provided updates on work being taken forward by the Department, reinforced the need for HPSS organisations to report serious adverse incidents and near misses to the Department as part of arrangements for establishing a system of clinical and social care governance as outlined in MMcG/118, in line with the wider policy direction for quality and safety set out in '*Best Practice Best Care'*, and requested detail of senior managers within HPSS organisations who had responsibility for the reporting and management of adverse incidents. I attach copies of the circulars at MMcG/123 and MMcG/124.

13.10. In March 2006, the Department published Quality Standards for Health and Social Care to underpin the statutory duty of quality on the HSC Board and HSC Trusts. They were designed to complement standards

and other guidelines already in use by organisations and provide a baseline against which organisations could assess themselves and demonstrate improvement. I attach a copy of the Standards at MMcG/81.

13.11. The Department also issued *'Safety First: A Framework for Sustainable Improvement in the HPSS'* in 2006. This document outlined a commitment to the ongoing development of a safer service to improve outcomes and service user experiences in clinical and social care settings and a policy focus on linking quality and safety. I attach a copy of the Framework at MMcG/125.

13.12. In April 2006, the Department issued the *'Guidance Document – How to classify incidents and risk'* providing guidance for HPSS organisations in developing or reviewing processes to assess adverse incidents and risk implications. I attach a copy of the guidance at MMcG/126.

13.13. The Department issued '*Supporting Safer Services'* reports to HSC organisations in June 2006 and December 2007 providing an overview and key learning from Serious Adverse Incidents reported to the Department in the previous financial year. A further report was issued in September 2011 covering learning from Serious Adverse Incidents reported to the Department between April 2007 and April 2010 before responsibility transferred to the Health and Social Care Board and Public Health Agency. I attach copies of the three reports at MMcG/127, MMcG/128 and MMcG/129.

13.14. In March 2007, the Department issued further circulars on amendments regarding the reporting and follow-up on Serious Adverse Incidents. I attach copies of the circulars at:

- MMcG/130 HSC (SQS) 19 2007 - Reporting and Follow-up on Serious Adverse Incidents and Reporting on breaches of patients

waiting in excess of 12 hours in Emergency Care Department (2007) and

- MMcG/131 HSS(SQSD) 34 2007 HSC Regional Template and Guidance for Incident Review Reports (2007).

13.15. In January 2009 the 2009 Act came into effect. This Act restructured the Health and Social Care system with a view to putting in place a modern, citizen-centred, accountable and high-quality system of public administration and restated at Section 2 the duty on the Department to promote an integrated system of health care. Section 2(3)(i) sets out a duty on the Department to make and maintain effective arrangements to monitor and hold to account health and social care bodies for the discharge of their functions. Section 25 transferred the duties of the former Mental Health Commission to RQIA, those duties ae set out in Article 86 of the Mental Health (Northern Ireland) Order 1986. In March 2009, the Department wrote to Health and Social Care organisations about a review of arrangements for the reporting of Serious Adverse Incidents. I attach a copy of the circular at MMcG/132.

13.16. A further Departmental circular, issued on 30 April 2010, on revised arrangements for Severe Adverse Incident advised that HSC organisations were to cease routinely reporting SAIs to the Department from 1 May 2010 and in line with operational guidance issued by the HSCB/PHA, reporting of all incidents meeting the SAI criteria should be to the HSCB from 1 May 2010. I attach a copy of the circular at MMcG/133.

13.17. On 28 May 2010, the Department issued the circular *'Establishment of an Early Alert System'* which provided guidance on the operation of a new Early Alert System intended to ensure that the Department was made aware in a timely fashion of significant events occurring within HSC organisations. I attach a copy of the circular at MMcG/134.

13.18. In November 2011 the Department launched “Quality 2020 - a 10 Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland”. As part of the strategy, Objective 1 set out that as part of an increased emphasis on high quality services, a key element to gauge the success would be an increase in the number of adverse incidents and near misses being reported as the outworking of a stronger reporting and learning culture, with a related decline in the number of serious adverse incidents. I attach a copy of the strategy at MMcG/135.

13.19. The Department issued further circulars on the operation of the Early Alert system in 2014, 2016, 2019 and 2020. I attach copies of these circulars at:

- MMcG/136 Circular HSC (SQSD) 07 14 Proper use of the Early Alert System Reminder (2014);
- MMcG/137 Circular HSC (SQSD) 64 16 Updated guidance on the operation of the Early Alert System (2016);
- MMcG/138 Circular HSC (SQSD) 05 19 Updated guidance on the operation of the Early Alert System (2019) and
- MMcG/139 Circular HSC (SQSD) 05 19 Use of the Early Alert System with respect to COVID 19 incidents (2020).

13.20. In terms of the Department’s process, on receipt of the Early Alert proforma, the Department’s Early Alerts Team will circulate to the appropriate policy lead/leads within the Department to consider what further action (if any) they need to initiate in relation to their policy area. This may include liaising with the HSC organisation to ascertain further details surrounding the event, reminding the HSC organisation to give proper consideration as to whether or not the event also meets the criteria to be categorised as an SAI, liaising with the Private Office, the Press Office and other relevant policy areas regarding handling arrangements including preparation of a formal submission to Minister,

or any other immediate action deemed necessary. I attach an example of an internal memo on the operation of the System at MMcG/140.

13.21. Internal departmental guidance for the operation of the EA procedure and actions for departmental officials upon receipt of an EA, including for those officials in the policy area, are attached at MMcG/141.

Section 14: Module 3k:(Risk assessments and planning regarding changes of policy)

14.1 The Department has taken a concerted policy approach to the development of evidence-based governance and risk management arrangements across its arms-length bodies to improve and protect patient safety.

Risk assessments

14.2. The Department commissioned HRRI Healthcare Risk Resources International consultants in 1998 to undertake a survey of the preparedness of HPSS bodies to deliver sound risk management. The survey results in 1999 provided the Department with baseline information on all of the dimensions of risk management across the HPSS, including the reporting of adverse incidents, and this provided further impetus for the work of developing the policy guidelines on risk management and governance which were set out in the *'Best Practice, Best Care'* consultation paper in 2001. I attach a copy of *'Best Practice Best Care'* at MMcG/117.

14.3. In March 2002, the Department adopted a common model of risk assessment for the Department and all of its associated bodies, including the HPSS. The Australia/New Zealand model of risk management, which was already in use in the NHS in England, was adopted and promulgated to the HPSS through circulars on Corporate Governance and the Statement of Internal Control. I attach a copy of

these circulars at MMcG/142 and MMcG/143.

14.4. In January 2003, the Department issued guidelines to the HPSS on the implementation of clinical and social care governance. I attach a copy of this circular at MMcG/144.

14.5. The circular stressed the importance of organisations taking corporate responsibility for performance and for providing the highest possible standard of clinical and social care. The circular also placed an emphasis on adverse incident management.

14.6. In April 2003, the statutory duty of quality on HPSS organisations came into effect and core risk management standards were introduced as part of the establishment of controls assurance standards across the HPSS. These arrangements also emphasised the need for an adverse incident reporting system to be in operation and the specific Controls Assurance Standard for Risk Management included a criterion on adverse incidents which requires 'an agreed process for reporting, managing, analysing and learning from adverse incidents' to be in place. I attach an example of the Standard at MMcG/145.

14.7. In 2005, a project was convened under the auspices of the Safety in Health and Social Care Steering Group to enhance systems and processes in the HPSS to better manage adverse incidents and risk arrangements. This Group was mainly associated with governance and providing assurance around operating systems and processes. The Group was formally stood down via e-mail in February 2020. I attach a copy of the e-mail at MMcG/146.

14.8. In April 2006, the Department issued guidance to the HPSS on how to classify incidents and risk to assist organisations in developing or reviewing processes to assess adverse incidents and their risk implications. I attach a copy of the guidance at MMcG/126.

14.9. This was a product of the Safety in Health and Social Care Steering Group I referenced above, and designed to promote greater consistency of approach within the HPSS and facilitate sharing of learning arising from adverse incidents.

14.10. '*Promoting Quality Care'*, which I have attached at MMcG/41, provided guidance on the assessment and management of risk in mental health and learning disability services, and supported organisations in managing the potential risk that service users may cause harm to themselves or others.

14.11. In 2018, the Department replaced the Australia/New Zealand model of risk management with an updated approach on the basis that the Australia/New Zealand model had not been updated since 2009 and had since been superseded by an International Organisation for Standardisation (ISO) standard; ISO 31000:2018. The Department wrote to its arms-length bodies in June 2018 to advise of the change in approach. I attach a copy of this letter at MMcG/147.

Policy Changes

14.12. The policy development and review process in Northern Ireland is legislatively underpinned by the statutory duties on equality and good relations under Section 75 of the Northern Ireland Act 1998. All new policies or proposals to change existing policies are required to undergo a screening process to identify any potential adverse impacts on the groups specified in Section 75. Impacts on, and the protection of, human rights are also assessed.

14.13. Policy development and review within the Department is carried out in line with *'A Practical Guide to Policy Making in Northern Ireland'* which was first published by the then Office of the First Minister and Deputy First Minister (OFMDFM) in 2003 and applies to all Northern Ireland Government Departments. I attach a copy of the guidance at

MMcG/148. The guidance covers common elements of the policy development process, including the identification and active management of risk.

Section 15: Modules 3l (Procedures to provide assurance regarding adherence to policies)

15.1 I have already set out the broad accountability arrangements for the HSC system in paragraphs 2.9 to 2.33. In September 2011, the Department issued the Framework Document to meet the duty placed upon it under section 5(1) of the 2009 Act. I attach a copy of the e-mail and Framework at MMcG/149 and MMcG/31 respectively.

15.2 The Framework Document sets out the high-level framework within which HSC bodies must operate. It also sets out their roles and functions and the systems which govern their relationships with each other and with the Department. These systems include submission to the Department of annual Statements on Internal Control and mid-year assurance statements, participation in bi-annual accountability reviews, demonstrating compliance with controls assurance, quality standards and risk management strategy requirements (all outlined in the Corporate Control Dimension, pages 43 to 46) and the implementation of statutory functions under agreed Schemes of Delegation (Safety and Quality Dimension, pages 46 to 50).

15.3 In 2005 the Department issued Corporate Governance in the Health and Personal Social Services – Code of Conduct and Code of Accountability (2005) and an updated Code of Conduct & Code of Accountability for Board Members of Health & Social Care Bodies in July 2012. I attach a copy of the 2005 Code at MMcG/150 and a copy of the issuing letter and 2012 code at MMcG/151.

15.4 The Code sets out the basis on which members of HSC boards should fulfil the duties and responsibilities conferred upon then by the

Department. The contents of the Code are kept under review by the Department to reflect best practice in this area and revisions and updates are issued accordingly.

15.5 In May 2021, the Department issued the *'HSC Board Members Handbook – A Resource to Support the Delivery of Safe and Effective Care'* I attach a copy of the handbook at MMcG/152.

15.6 This handbook is the first product to emerge from the Inquiry into Hyponatraemia Related Deaths report. It addresses key recommendations on leadership, clinical and social care governance and Board effectiveness, and has been developed as a resource to assists Boards to scrutinise the safety and quality of services. The handbook has been produced for, and by, Non-Executive Directors to prepare and support them in their important leadership role with a strong focus on quality improvement, learning from error and ensuring that services users and staff have a voice.

15.7 The Learning Disability Service Framework, which the Department launched in 2012, and I have included at MMcG/33, contained 34 standards for learning disability services, along with associated key performance indicators and anticipated outcomes. Performance against Service Frameworks was overseen by the Service Framework Programme Board, chaired by the Chief Medical Officer. Implementation and monitoring of progress towards delivery of the Framework was the joint responsibility of the HSCB and PHA, who provided twice yearly progress reports to the Programme Board.

15.8 In November 2012 the Department issued an assurance and accountability framework for the sponsorship of the Departments Arm's Length Bodies. I attach a copy of the 2012 sponsorship framework at MMcG/153. The aim of the sponsorship framework was to provide the Department (and thus Minister) with assurance that each ALBs was delivering on its Programme for Government, Ministerial and statutory responsibilities and Department policies and strategies.

15.9 As part of this assurance process, the Department holds Assurance and Accountability meetings with each HSC body twice yearly, at mid and end-year. The Permanent Secretary, in their role as Departmental Accounting Officer, aims to chair all end-year accountability meetings and certain mid-year accountability meetings, although this can be delegated to the Departmental Executive Board Member at Deputy Secretary level, with Sponsorship responsibility for the ALB. As an example of the outputs of these meetings, I attach the minutes from the 2010/11 end-year accountability meeting with the Belfast Trust at MMcG/154.

15.10 The sponsorship framework also included arrangements for Departmental sponsorship of Arm's Length Bodies, with sponsor responsibility for individual organisations resting with an identified branch within the Department. The designated Sponsor branch acted as the primary point of contact for the Arm's Length Body on non-financial management and performance. For example, the Public Health Agency are sponsored by the Health Development Policy Branch within the Department. To support this function, the sponsor branch issued a Sponsor Branch Checklist to the Arm's Length Body each financial year and monitored compliance with this. Any issues or concerns arising from this process were escalated within the Department. I attach an example of a checklist at MMcG/155.

15.11 In 2013, the Department issued guidance to its Arm's Length Bodies on completing Governance Statements for their organisation. I attach a copy of the guidance and pro-forma at MMcG/156 and MMcG/157.

15.12 Guidance on the completion of Arm's Length Bodies Governance Statements is issued annually within the Manual of Accounts. I have included an example at MMcG/156.

15.13 In 2016, the assurance and accountability framework was replaced by the DoH Sponsorship Handbook. The Handbook is kept under regular

review with updates issued in line with developments in best practice in this area. I attach copies of the handbook at MMcG/158 and MMcG/159.

Delegated statutory functions

15.14 From 1972 until 1994 as set out in the 1972 Order, the 1991 Order and the Health and Personal Social Services (Northern Ireland) Order 1994 (the 1994 Order), the Health and Social Services Boards were the 'named authority' responsible for the delivery of certain statutory functions relevant to social care provision. The establishment of HSS Trusts in 1991 and the introduction of the purchaser/provider split within the HSS system, placed responsibility for the commissioning of services in Northern Ireland on the then Health and Social Services Boards, and more recently, following the Review of Public Administration and the introduction of the 2009 Act, jointly on the Health and Social Care Board and the Public Health Agency. The responsibility for service provision was placed on the Health and Social Care Trusts and the Health and Personal Social Services (Northern Ireland) Order 1994 (the 1994 Order) (Article 3) provided for the Health and Social Services Boards to delegate the discharge of these statutory functions to HSS Trusts.

15.15 The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions from the HSC Trusts to the Health and Social Care Board (and its predecessors) to the Department has been in place since then, as set out in Circular HSS (Statutory Functions) 1/2006 that I have included at MMcG/160. Arrangements for professional oversight are designed to ensure that Delegated Statutory Functions are discharged in accordance with the law and to relevant professional standards within a system of delegation.

15.16 The powers and duties then delegated through the Health and Social Care Board and subsequently SPPG are specified in Schemes for the

Delegation of Statutory Functions, and these are submitted to the Department for approval. The Schemes also outline the principles and values that underpin the discharge of Delegated Statutory Functions, and the quality control framework whereby monitoring and reporting of these functions is an integral part of the corporate accountability and professional governance arrangements.

15.17 Responsibility for the professional oversight of the system for the performance management and quality assurance arrangements for the discharge of certain specified Delegated Statutory Functions in Social Care rests with the Office of Social Services (OSS) within the Department. To manage the performance management and quality assurance arrangements for these functions, the OSS issue circulars providing frameworks, guidance and detail on legislative and structural arrangements. I attach an example circular at MMcG/161.

15.18 In terms of reporting, professional oversight is an ongoing process and takes place throughout the year with arrangements in place for any issues raised to be dealt with. The Department also receives a year-end overview report on the Discharge of Statutory Functions, from the HSCB (going forward from SPPG), to identify any issues requiring escalation. The report is considered by the Chief Social Work Officer for any appropriate action. I attach as an example a copy of the HSCB overview report for 2016/17 at MMcG/162, and the Department's subsequent advice to the Chief Social Work Officer on this at MMcG/163.

Section 16: Modules 3m (Policies and procedures for further training for staff/continuing professional development)

16.1. The Department recognises the importance of training and continued professional development for staff to ensure they are supported to be effective in their roles to deliver high quality and safe services to the public.

16.2. The Northern Ireland Social Care Council was established by the Department on 1 October 2001 under Part 1, Section 1 of the Health and Personal Social Services Act (Northern Ireland) 2001. It replaced the Central Council for Education and Training in Social Work. The Council's aim is to support high quality standards of social work and social care, and they do this by regulating workforce standards and promoting continuous training and learning. The importance of continued professional development and training for social work and social care staff has been reinforced by NISCC Post Registration Training and Learning requirements. I attach an example of these requirements at MMcG/164.

16.3. NIPEC was established by the Northern Ireland Assembly in 2002 under the Health and Personal social Services Act as an NDPB (Non-Departmental Public Body) to support the development of nurses and midwives by promoting high standards of practice, education and professional development. NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

16.4 The Department recognises that effective arrangements for staff appraisal are good employment practice, leading to improved staff performance, higher staff satisfaction and better patient outcomes.

16.5. The vast majority of staff in the HSC are employed under Agenda for Change terms and conditions. Prior to this, separate pay scales and bargaining arrangements were in place, under Whitley industrial relations systems, across the disparate professions and roles. Agenda for Change allocates posts to a range of standardised pay bands, dependent on the responsibilities of the job under the NHS Job Evaluation Scheme. As part of the Agenda for Change Agreement introduced in Northern Ireland in 2004, a Knowledge and Skills Framework was developed as a tool for describing the knowledge and skills staff need to apply at work in order to deliver high quality services. I have attached a copy of the NHS Knowledge and Skills Framework

(KSF) at MMcG/165.

16.6. The NHS KSF was designed to form the basis of a development review process. This was an ongoing cycle of review, planning, development and evaluation for all staff which links organisational and individual development needs.

16.7. The NHS KSF and the related development review process were essentially about lifelong learning. The National Agreement included a commitment to annual development reviews for all staff and a commitment to the development of all staff.

16.8. In 2006, the Department published the '*Personal Social Services, Development and Training Strategy*.' I attach a copy at MMcG/166.

16.9. The Strategy set the policy direction for the development of the Personal Social Services workforce over the ten-year period from 2006 - 2016, and supported the Department's Safety and Quality agenda by ensuring the social work and social care workforce had access to relevant training and development opportunities.

16.10. The Strategy also committed to improve the qualification base of the social work and social care workforce, and to link training and qualifications with registration with the Northern Ireland Social Care Council.

16.11. The requirement for employers to train and develop staff is clearly set out in the NISCC Code of Practice for Social Care Employers MMcG/167 (paragraphs 4.1 - 4.6) and is also an integral part of the clinical and social care governance arrangements which are part of an employer's 'duty of quality'. The Minimum Care Standards and associated Regulations for services regulated under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (Article 38) (the 2003 Order) reinforce

employers' responsibilities to ensure staff receive appropriate development and training for their roles and responsibilities. The Minimum Care Standards are published on the Department's website. Employers' compliance with all of these requirements are monitored by the Regulation, Quality and Improvement Authority.

16.12. In April 2009, the Department published 'A Workforce Learning Strategy for the Northern Ireland Health and Social Care Services 2009-2014. I attach a copy of this at MMcG/168.

16.13. The strategy recognises that effective learning and development underpins successful organisational performance. It supports the further development of a learning culture across the HSC, enabling individuals to progress in their careers, as well as supporting those staff whose career commitment is to their current posts.

16.14. Individual professions have taken forward their own learning and development strategies. This strategy seeks to build on those and reinforce common themes and policy directions. As outlined on page 8 of '*The Regional Workforce Planning Framework'* MMcG/169, employing organisations are responsible for ensuring that they have an appropriate and skilled workforce to deliver the services commissioned from them.

16.15. For social and social care workers the Department has produced and published a Learning and Improvement Strategy which sets 6 strategic priorities for employers, namely relationship-based practice, skilled, resilient and confident workforces, continuous learning and improvement, effective leadership and management, collaboration and partnership, and practicing in a digital world. I have included a copy this at MMcG/170. Trusts were required to report to HSCB, and now SPPG, on the achievement of those priorities and the Department maintains an oversight of the achievement. SPPG allocates funding to Trusts which is used to provide mandatory training and to service the Department'

strategic priorities. Trusts must account to SPPG on the outcomes from those spends.

16.16. The Strategy supported the development of a core set of skills for all staff within the HSC, which are essential for anyone working within health and social care, and necessary to the quality of services.

Section 17: Module 4a (Workforce plans for disability care 1999 – 2021 (Trust and Department of Health))

17.1. The Department recognises that the people who work in Northern Ireland's health and social care system are the system's greatest strength, and the growth and development of the Health and Social Care workforce is a key priority for the Department.

17.2. The Department is responsible for strategic long term workforce planning across all sectors of Health and Social Care services to ensure the steady supply of skills for the future Health and Social Care workforce. Immediate (or vacancy) workforce planning to manage service delivery and vacancies falls to each employing HSC Trust. I include a copy of The Regional Workforce Planning Framework at MMcG/169 which identifies the specific workforce planning responsibilities of the Department and HSC organisations (pages 6 – 8). The Department's role is described as strategic and regional, while the role of HSC Trusts is ensuring that they have an appropriate and skilled workforce to deliver commissioned services, while using relevant information to inform operational workforce plans which are to be reviewed annually. Workforce issues, including vacancy rates, frequently appear on the Ground Clearing/Accountability meetings with HSC Trusts.

17.3. In November 1998 the Minister for Health and Social Services acknowledged that a service-wide strategic framework for people management would be required underpinned by a Human Resources

Strategy for the HPSS, and commissioned the development of this strategy. A Human Resource Strategy Steering Group was established in September 1999 to develop the framework. Work commenced at this stage which culminated in the publication of '*The Employer of Choice: Caring for Staff, Caring for Service Users – A strategy for managing and developing people in the Health and Personal Social Services"* in 2001. I attach a copy of this at MMcG/171.

17.4. The Strategy aimed to position the HPSS as the employer of choice, recognising that improving services depended on attracting, retaining and developing the best staff. It identified workforce planning, recruitment and retention, education and training, employee relations, equality and fairness and improving working lives as key areas to be addressed.

17.5. In 2009, the Department published the Bamford Action Plan 2009-2011, in support of the Northern Ireland Executive's response to the Bamford Review recommendations. The Action Plan included a commitment to 'complete a workforce planning study for Mental Health and Learning Disability health and social care services'. The Department commissioned Deloitte to undertake a workforce planning review of Mental Health and Learning Disability services, and I attach a copy of the final report of that review provided by Deloitte at MMcG/172.

17.6. The Deloitte report concluded that given the economic climate and the restraints and challenges of budgets, a considerable proportion of the change within the mental health and learning disability workforce would be through reform and modernisation of the existing workforce. The follow up Bamford Action Plan 2012 – 2015, included at MMcG/40 noted that the workforce review findings would be taken forward as an integral part of the work to develop mental health and learning disability services in general.

17.7. The 2012-15 Bamford Action Plan also included a commitment (Action 53) to develop a UK wide framework for Learning Disability nurses. A Northern Ireland action plan to implement the UK wide framework for learning disability nurses, "Strengthening the Commitment", was launched in July 2014. I have included a copy of this at MMcG/57. Work was initiated in 2015 to undertake a review of the learning disabilities nursing workforce across NI to include all sectors, as I referenced earlier in my statement at paragraph 6.14.

17.8. In 2016 the report of the Expert Panel on transforming health and social care chaired by Professor Rafael Bengoa, *'Health and Wellbeing 2026: Delivering Together'* reaffirmed effective workforce planning as a key enabler in transforming delivery of health and social care services, and committing to ensuring the development of a Workforce Strategy covering all aspects of the HSC workforce, including retention and recruitment, opportunities for introducing new job roles and reskilling and upskilling initiatives.

17.9. In response to this, the Department published in 2018 the *'Health and Social Care Workforce Strategy 2026: Delivering for our People'*. I have attached a copy of this at MMcG/173.

17.10. The Strategy includes a detailed analysis of the workforce problems and challenges facing health and social care in Northern Ireland, and it was produced following significant engagement with the workforce. Its aim is to transform how health and social care is delivered in Northern Ireland, and it sets out ambitious goals for a workforce that will match the requirements of a transformed system. It also addresses the need to tackle serious challenges with supply, recruitment and retention of staff. The strategy aims by 2026 to meet workforce demands and the needs of the health and social care workforce.

17.11. To ensure flexibility in the delivery of the Strategy, three consecutive action plans are planned for the life of the Strategy. The first action

plan covering the period 2018-2020 is included within the original Strategy document on pages 29 to 42. A copy of the Strategy is attached at MMcG/173.

17.12. The covid pandemic and its impact delayed the development of the second action plan. It was published in June 2022. The Department is now in the process of working with stakeholders in the implementation of this second action plan which covers the period 2022/23 to 2024/25. A copy of this is attached at MMcG/174.

17.13. The Muckamore Abbey Hospital HSC Action Plan was developed by the Department in 2019 in response to 'A Way To Go', the report of the Level 3 SAI Review of allegations of abuse at the hospital. I attach an example of the Action Plan at MMcG/35. This contained an action (A37 – pages 23/24 in MMcG/35) requiring the Department to develop an evidence-based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce for learning disability services, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services.

17.14. In order to address this action, the Department commenced work on a Regional Workforce Review across Adult Learning Disability Teams and Services in late 2021, and this is ongoing.

Section 18: Other relevant information

18.1. No other detail to add.

Section 19: Conclusion

19.1. I would conclude by thanking the Inquiry for the invitation to provide an evidence statement, and trust that the information I have provided will assist the panel as it carries out this important work. I have endeavoured to address the topics identified in the Rule 9 letter within

the framework identified in that correspondence. Should the panel require any further information or clarification on any of the areas I have covered in my statement, I am of course very happy to provide that.

19.2. I would reiterate the message that was conveyed in the Department's opening statement to the Inquiry, that the Department will co-operate with and assist the Inquiry in any way that it can. The Department welcomes the rigorous independent scrutiny that the Inquiry will bring to the issues identified in its Terms of Reference.

Section 20: Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed: 

Date: 13th February 2023

List of Exhibits (Mark McGuicken)

MMcG/1 HSC Governance Structure

MMcG/2 DoH List of statement abbreviations

MMcG/3 People First - Community Care in Northern Ireland for the 1990s

(1990) MMcG/4 Accountability Framework for Trusts (1993)

MMcG/5 Health and Wellbeing 2026 Delivering Together (2016)

MMcG/6 The Commissioning Plan Direction (Northern Ireland) 2009-2010

MMcG/7 The Commissioning Plan Direction (Northern Ireland) 2010-2011

MMcG/8 The Commissioning Plan Direction (Northern Ireland) 2011-2012

MMcG/9 Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2012-2013

MMcG/10 Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2013-2014

MMcG/11 Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2014-2015

MMcG/12 Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2015-2016

MMcG/13 Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2016-2017

MMcG/14 Draft Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2017-2018

MMcG/15 Draft Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2018-2019

MMcG/16 Draft Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019-2020

MMcG/17 Managing Public Money Northern Ireland (2008)

MMcG/18 POC Definitions Guidance (1996)

MMcG/19 Summary of Learning Disability Spend by Trust 1999 – 2021

MMcG/20 Mental Health Spend by Trust - 1999-2021

MMcG/21 Muckamore Abbey Hospital Budget & Expenditure 2016 17-2018

19 MMcG/22 Fit for the Future - consultation document 1998

MMcG/23 Fit for the Future - summary of consultation responses 2001

MMcG/24 The Acute Hospital Review part 1 (2001)

MMcG/25 The Acute Hospital Review part 2 (2001)

MMcG/26 The Acute Hospital Review part 3 (2001)

MMcG/27 The Acute Hospital Review part 4 (2001)

MMcG/28 Developing Better Services (2002)

MMcG/29 Independent Review of Health and Social Care Services in Northern Ireland 2005

MMcG/30 A Healthier Future 2005

MMcG/31 DHSSPS Framework Document (2011)

MMcG/32 Letter to Executive colleagues re Bamford evaluation report (2016)

MMcG/33 Service Framework for Learning Disability (2015)

MMcG/34 Service Framework for Learning Disability Programme Board ToR (2015)

MMcG/35 MAH HSC Action Plan (2020)

MMcG/36 DHSS Review of Policy for People with a Learning Disability (1995)

McMcG/37 Equal Lives - Review of policy and services for people with a learning disability in Northern Ireland (2005)

McMcG/38 Care At Its Best Report (2005)

MMcG/39 Bamford Action Plan 2009-2011

MMcG/40 Bamford Action plan 2012-15

MMcG/41 Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in MH and LD Services (2010)

MMcG/42 Transforming Your Care - A Review of HSC in Northern Ireland (2011)

MMcG/43 Quality 2020 A 10-year strategy to protect and improve quality in health and social care in Northern Ireland (2011)

MMcG/44 Evaluation of the 2009-2011 Bamford Action Plan (2012)

MMcG/45 Letter from Michael McBride re Service Framework (2019)

MMcG/46 Circular- Interventions for People with Learning Disabilities Whose Behaviour Challenges July 2015

MMcG/47 Circular - Mental Health Problems in People with Learning Disabilities - Prevention Assessment and Management November 2016

MMcG/48 HSC SQSD 13 22 NICE Clinical Guidelines Process for Endorsement Implementation Monitoring and Assurance in NI (2022)

MMcG/49 MAH HSC Action Plan (2019)

MMcG/50 Future nurse Standards of proficiency for registered nurses (2018)

MMcG/51 NMC Code (2018)

MMcG/52 Review of the Nursing Midwifery and Health Visiting Workforce Final Report' (2002)

MMcG/53 Nursing and Midwifery Review Summary 2009

MMcG/54 Review of Clinical Supervision for Nursing in the HPSS (2006)

MMcG/55 Partnership for Care Northern Ireland Strategy for Nursing and Midwifery 2010 to 2015 (2010)

MMcG/56 Strengthening the Commitment (2012)

MMcG/57 NI Action Plan for Strengthening the Commitment Final draft (2016)

MMcG/58 NI Action Plan for Learning Disability Nursing Progress report 2017

MMcG/59 A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2025)

MMcG/60 Nursing and Midwifery Task Group report and recommendations (2020)

MMcG/61 Professional Alerts Policy (2010)

MMcG/62 Letter confirming CNO Alert policy revoked (2022)

MMcG/63 Letter to HPSS Trusts Boards re Revocation of the Scheme for the Issue of Alert Notices 2006

MMcG/64 Guidance on Restraint and Seclusion in Health and Personal Social Services 2005

MMcG/65 Revised Circular Deprivation of Liberty Safeguards 2010

MMcG/66 A Mental Health Action Plan 2020

MMcG/67 Mental Health Strategy 2021-2031

MMcG/68 Protocol for Joint Investigation of alleged and Suspected Cases of Abuse of Vulnerable Adults - Dec 2003

MMcG/69 Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance (2006)

MMcG/70 Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009)

MMcG/71 Adult Safeguarding in Northern Ireland Regional and Local Partnership Arrangements March 2010

MMcG/72 Adult Safeguarding - Prevention and Protection in Partnership (2015)

MMcG/73 Protocol for Joint Investigation of Adult Safeguarding Cases (2016)

MMcG/74 Use and Control of Medicines (2004)

MMcG/75 Letter from CPO advising no further editions of Use and Control of Medicines (2013)

MMcG/76 The Safe and Secure Handling of Medicines A Team Approach - A revision of the Duthie Report 1988 (2005)

MMcG/77 Medicines Management Controls Assurance Standard (2014)

MMcG/78 Letter to ALB Chief Executives Review of Controls Assurance Standards (2018)

MMcG/79 Controls Assurance Standards Update Summary (2018)

MMcG/80 Letter from CPO re Discontinuation of Medicines Management and Optimisation (2018)

MMcG/81 Quality Standards for Health and Social Care (2006)

MMcG/82 The Safer Management of Controlled Drugs - A guide to good practice in secondary care (Northern Ireland) (2012)

MMcG/83 Safer Management of Controlled Drugs Guidance on Standing Operating Procedures for Northern Ireland (2009)

MMcG/84 Safer Management of Controlled Drugs A Guide to Strengthened Governance Arrangement in Northern Ireland (2015)

MMcG/85 Northern Ireland Medicines Optimisation Quality Framework (2016)

MMcG/86 Transforming Medication Safety in Northern Ireland (2020)

MMcG/87 Letter from CPO - seeking support for cost effective prescribing policy 2021

MMcG/88 HSC Policy Statement on Implementation of Medicines Optimisation & Cost (2021)

MMcG/89 A Strategy for the Allied Health Professions in Northern Ireland 2012-2017 (2012)

MMcG/90 UK Allied Health Professions Health Strategic Framework 2019-2024 (2019)

MMcG/91 A Strategy for the Development Of Psychological Therapy Services (2009)

MMcG/92 Speech, Language and Communication Therapy Action Plan Improving Services for Children and Young People 201112 201213 (2011)

MMcG/93 Health and Well-being into the next Millennium (1996)

MMcG/94 Review of Care in the Community February 2000

MMcG/95 Review of Community Care First Report 2002

MMcG/96 Goggins Outlines Action For Learning Disability Hospitals (2007)

MMcG/97 Regional Resettlement Team Terms of Reference (2008)

MMcG/98 Priorities for Action 2007-2008

MMcG/99 Permanent Secretary Statement and Apology on resettlement (2019)

MMcG/100 HPSS Complaints Procedure (1996)

MMcG/101 Directions to Health and Social Services Boards on Procedures for Dealing with Complaints about Family Health Services Practitioners 1996

MMcG/102 Directions to Health and Social Services Trusts and Boards on HPSS Complaints Procedures 1996

MMcG/103 Directions to Health and Social Services Boards on Miscellaneous Matters Concerning Complaints 1996

MMcG/104 The General Medical and Pharmaceutical Services (Amendment) Regulations (Northern Ireland) 1996

MMcG/105 The General Dental Services (Amendment) Regulations (Northern Ireland) 1996

MMcG/106 The General Ophthalmic Services (Amendment) Regulations (Northern Ireland) 1996

MMcG/107 The Health and Personal Social Services (Fundholding Practices) Amendment Regulations (Northern Ireland) 1996

MMcG/108 Guidance for Staff on relations with the Public and the Media (1996)

MMcG/109 Guidance on Handling HPSS Complaints Hospital & Community Health & Social Services (2000)

MMcG/110 Report on Good Practice Review of Complaints Procedures in the HPSS (2003)

MMcG/111 Guidance on Handling HPSS Complaints Hospital and Community Health and Social Services (2009)

MMcG/112 Guidance in Relation to the HSC Complaints Procedure (2019)

MMcG/113 Circular Public Interest Disclosure (NI) Order 1998 Whistleblowing in the HPSS (2000)

MMcG/114 Whistleblowing - Circular ref HSS (F) 07/2009 (2009)

MMcG/115 Ministers Letter to HSC Staff Actively Encouraging Whistleblowing

(2012)

MMcG/116 HSC Whistleblowing Framework & Model Policy (2017)

MMcG/117 Best Practice Best Care Consultation paper (2001)

MMcG/118 Governance in the HPSS Clinical and Social Care Governance Guidelines for Implementation (2003)

MMcG/119 Reporting and Follow Up on Serious and Follow Up on Serious Adverse Incidents - Interim Guidance (2004)

MMcG/120 Social Care Governance - A practice workbook (NI) (2nd edition) (2013)

MMcG/121 Letter to ALBs to advise of establishment of new HSC Safety Forum (2008)

MMcG/122 HSC Safety Forum Annual report 2009-2010

MMcG/123 HSS PPM 05-05 Reporting of SAIs in the HPSS (2005)

MMcG/124 HSS(PPM) 02 2006 - Reporting and Follow Up on Serious Adverse Incidents (2006)

MMcG/125 Safety First: A Framework for Sustainable Improvement in the HPSS (2006)

MMcG/126 Circular HSS MD 12 2006 How to classify incidents and risk (2006)

MMcG/127 Supporting Safer Services report (2006)

MMcG/128 Supporting Safer Services report (2007)

MMcG/129 Supporting Safer Services report (2011)

MMcG/130 HSC (SQS) 19 2007 - Reporting and Follow-up on Serious Adverse Incidents and Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Department (2007)

MMcG/131 HSS(SQSD) 34 2007 HSC Regional Template and Guidance for Incident Review Reports (2007)

MMcG/132 HSC (SQSD) 22/2009 - Learning from Adverse Incident and Near Misses reported by HSC Organisations and Family Practitioner Services (2009)

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