SUMMARY OF
"A REVIEW OF SAFEGUARDING AT MUCKAMORE ABBEY HOSPITAL – A WAY TO GO"

Summary of "A Review of Safeguarding at Muckamore Abbey Hospital - A Way to Go"

Introduction

In late 2017, the Belfast Health and Social Care Trust commissioned an independent Review Team[1] to look at safeguarding practices at the Hospital between 2012 and 2017. They began their work in January 2018.

The reason for this was that there were allegations of abuse of patients by staff, which were raised in August 2017. There were also delays in the reporting of these incidents.

CCTV information gathered at the Hospital revealed staff behaviours, which resulted in harm to patients. This led to 19 precautionary staff suspensions and a large police investigation which is continuing.[2] Separately, a team of staff was commissioned to view over 5,000 hours of CCTV images.

This summary is based on the Independent Review Team's report which was submitted to the Belfast Trust during November 2018 and shared with the families whose relatives are known to have been harmed.

What the Review Team did

There were five sets of activities. The Team;

1) Read the Hospital's safeguarding files, the Regulation and Quality Improvement Authority's (RQIA) reports and the Health and Social Care Board's information about safeguarding in Northern Ireland
2) Met the Hospital's managers and staff, patients, relatives, advocates, a Director and Inspectors from the RQIA
3) Discussed findings, emergent lessons and ways of setting these out in a report
4) Wrote and shared summaries about: the quality of care across settings; an updated history of the Hospital; the Hospital's safeguarding allegations and their outcomes; the Hospital's workforce; the themes within 61 RQIA reports; and the health needs of people with learning disabilities across the lifespan. These feature in the report's appendices with the RQIA's comments about the themes abstracted from inspection reports;

[1] Margaret Flynn (from Wales), Mary Bell (NI), Michael Brown (NI), Bryce McMurray (NI) and Ashok Roy (from England)

[2] At the time of writing, 23 January 2019

5) Facilitated multi-agency events during September 2018 to present the findings and build on the Team's recommendations.

What the Review Team found

- It is important to think about safeguarding "in context." The role of the Muckamore Abbey Hospital in improving the lives of people with learning disabilities and autism in NI and the limited availability of community based support and services characterised all meetings. The absence of adequate home-treatment, supported living and provider expertise is associated with people's crisis admissions to Muckamore Abbey Hospital. Delayed discharges mean that people become stuck in the hospital – which also means that the hospital's "assessment and treatment" main function is compromised.

- The RQIA reports do not provide a single overview of the Hospital since they focus on individual wards and produced hundreds of recommendations.

- Over a two-year period, the Hospital recorded 4,385 "adverse incidents." However, it is important to ask questions about these numbers because a single person may be associated with lots of incidents for example.

    - People's lives at the hospital are characterised by inactivity and boredom.
    - Hospital patients are significantly likely to be harmed by their peers.
    - A typical response to allegations of abuse made by patients about staff is 2:1 "observations." These create a demand for additional staff amounting to paying 50 more members of staff every week (50 whole time equivalents).

- Nurse staffing shortages feature in the hospital's Risk Register and there is a case that nurse staffing at the Hospital is insufficient to meet people's needs. However, a low ratio of registered staff was not a factor in the areas of the hospital where CCTV evidence show patients being harmed.

- People's families are hurt, distressed and angry that nobody intervened to halt the harm experienced by their relatives.

- It is possible that a policy requiring the involvement of the Police Service of NI (which has since been set aside) has skewed understanding of what proportionate responses to safeguarding allegations should look like.

- The extensive paperwork associated with safeguarding investigations and inspections did not uncover the abuses captured on CCTV.

- In parts of Muckamore Abbey Hospital, work practices were harmful and disproportionate, for example, the unmonitored use of seclusion. Its intensive

use by a small number of patients is anti-therapeutic. In contrast, families want it to be known that there are some staff who conscientiously provide compassionate care.

- It is not clear how closely Muckamore Abbey Hospital's safeguarding practice, as revealed in its files, align with the regional Safeguarding Operational Procedures.

- The credibility of patients' allegations is compromised by statements concerning their "history of making allegations", consultant's decision-making concerning their mental capacity as well as relative's views. .

- It is unclear how the Hospital dovetail safeguarding practice, RQIA inspections, professional regulation, police investigations, complaints, clinical governance and internal disciplinary processes.

- Advocacy is typically absent from considerations of safeguarding.

Important Considerations Highlighted by the Review Team

- Since Muckamore Abbey Hospital is not being used for rapid and short-term admissions, a network of leaders inside and outside the Hospital is required to address the over-reliance on Muckamore Abbey.

- Any coalition for progress must begin with the experiences of people with learning disabilities and their families.

- All services must demonstrate their readiness to plan for the care, support and treatment of infants and children with extensive medical and health support needs. Early intervention services are vital to the health and well-being of the adults with learning disability in the future.

The Review Team Identified the Following Lessons

a) The process of safeguarding should not be compromised by questions about a person's history, their mental capacity, the permission of their family or "thresholds"
b) The Muckamore Abbey Hospital's senior managers and clinicians must evidence the support they provide to staff who report harmful events and practices

c) Learning from people's families is invaluable. They must be treated as equal partners and heard on a continuous basis
d) Muckamore Abbey Hospital is part of the wider system located in the Belfast Trust, within the totality of Trusts, the Department of Health and the Legislative Assembly. Change needs to happen in all parts of the system simultaneously to ensure maximum benefit for patients and families. The case for major change is incontrovertible
e) Since it is not clear what the Hospital is achieving, it is highly unlikely that the families of infants and children with learning disabilities and complex neuro-developmental disabilities envisage Muckamore Abbey Hospital as part of their waiting future.

The Review Team's Recommendations

- Provide evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports

- An updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges is co-produced with people and their families. The transition to community-based services requires the contraction and closure of the Hospital…a life course vision of "age independent pathways," participative planning and training for service development remain to be described.

Patients' families recommended that:

- Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners
- Families and advocates should be allowed open access to wards and living areas
- There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use of seclusion at the Hospital
- The use of seclusion ceases
- The perception that people with learning disabilities are unreliable witnesses has to change
- People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives
- The Hospital's CCTV recordings are retained for at least 12 months

- Families are advised of lawful practices Muckamore Abbey Hospital may undertake with (i) voluntary patients and (ii) sectioned patients[3]
- Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives
- Families receive regular progress updates about what happening as a result of the review.

Hospital staff recommended that:

- An enhanced role for specialist nursing staff is set developed.
- Responses to safeguarding incidents and allegations are proportionate and timely
- Safeguarding documentation is substantially revised.

Senior managers from the Health and Social Care Trusts and the RQIA recommended that:

- A shared narrative is developed about the future of services
- Commissioners specify what "collective commissioning" means
- The transformation required in learning disability services must be values driven and well led
- The purpose of all of our services is clear
- All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing
- The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop[4]
- Time limited and timely Assessment and Treatment become the norm
- Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families
- Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.[5]

[3] A family was advised by a clinician seeking to section their relative that "It doesn't sit easy using seclusion on a voluntary patient"

[4] At the time of the feedback events (September 2018), the Hospital was addressing its low threshold for admissions

[5] For example, it may be helpful to distinguish the recommendations and points made in the review which may be addressed in the short term and in the medium term. For example, in the short term:

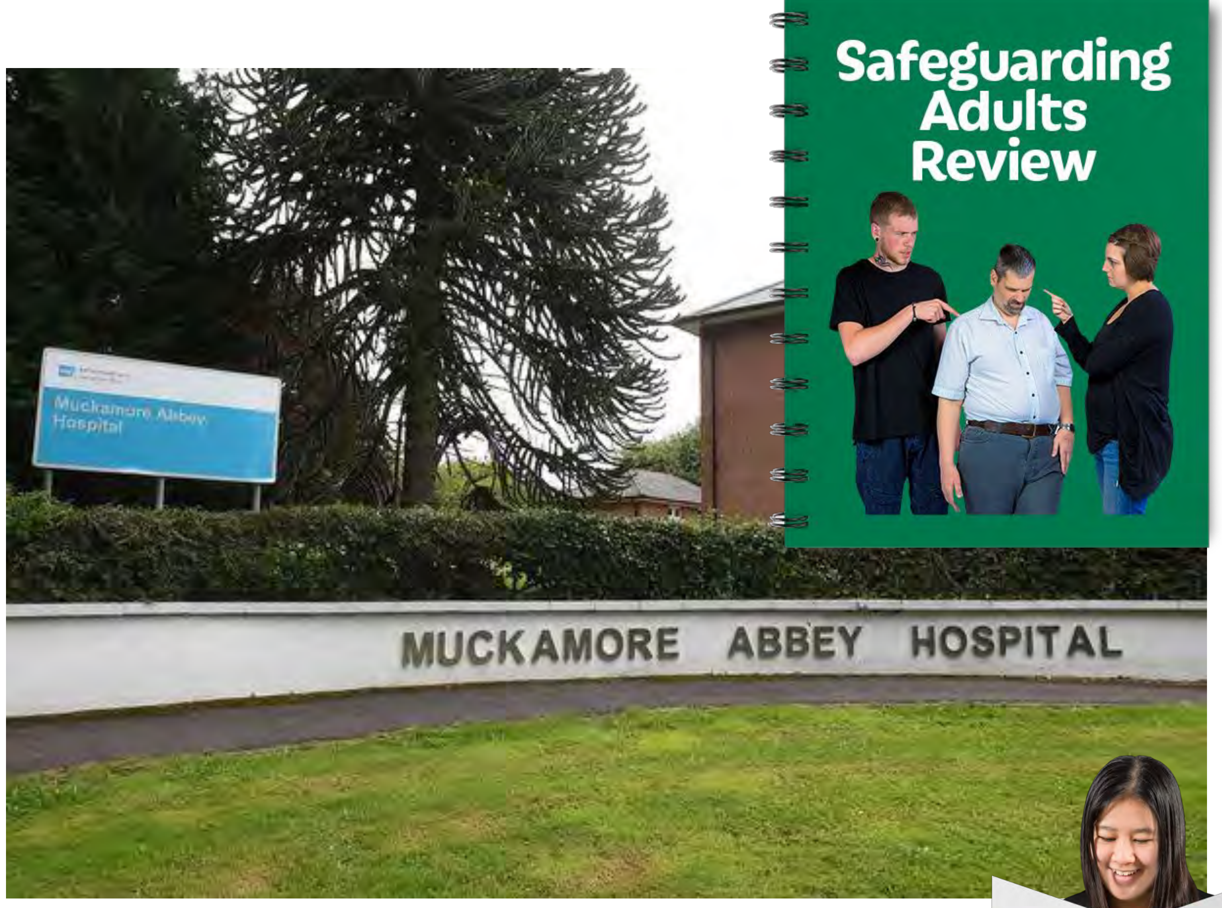
1. The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed - perhaps as an accountable group
2. The flow of admissions - especially readmissions - into the hospital should be restricted to halt the "revolving door" phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals
3. Existing patients need to spend time in and be visible in the community
4. Families and advocates should be allowed open access to wards and living areas

5. Monitoring and reporting of all restrictive practice - the use prn medication, physical restraint and seclusion must be strengthened

In the medium term:

1. Trusts should begin to build “all age care pathways” which bring together children’s and adult services, hospital and community services and health and social care and education services
2. Out of hours’ services should be enhanced using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups
3. The professional development of all front line staff must be prioritised using educational approaches based on providing better care rather than on formal course based approaches
4. New approaches to enhance housing capacity need to be accelerated to deal with ever increasing deman

A Way to Go
A Review of Safeguarding at Muckamore Abbey Hospital



Easy Read Summary

Muckamore Abbey Hospital has been in the news a lot.

At the end of 2017 some staff were asked to stay away from the Hospital.

There were pictures of them hurting people.

The police began an investigation.

In 2018, a team of five people were asked to take a close look at how the Hospital was dealing with people being hurt.

To do this, Margaret Flynn, Mary Bell, Michael Brown, Bryce McMurray and Ashok Roy read the files of people from different Hospital wards.

They talked to people about their lives, to people's families, to managers and staff at the Hospital and to inspectors who had been visiting the Hospital's wards.

They wrote a report about what they found. It says that:

When people move into the Hospital they get stuck there

Because there is not much to do, people get bored and some of them hurt each other

Sometimes they were hurt by staff who should be helping them

Some people were put in a room, alone, with only a chair. This is called "seclusion"

We do not know why some people were put in seclusion many times

Nobody at the Hospital checked when seclusion was used

Sometimes people were not believed when they reported what had happened to them

There were lots of safeguarding files and reports about people being hurt and lots of ward inspections – but people were still being hurt

All of this has made people angry and sad.

Margaret, Mary, Michael, Bryce and Ashok said that people should not be living at the Hospital. They want ordinary lives

people should only ever go into Hospital for a short time

the Hospital should close and new treatment services developed

people's families should help to make sure that people have helpful services wherever they live.

They told people's families, Hospital staff and managers in Northern Ireland about what they had found and asked for their ideas about what should happen.

People's families said that they want staff to understand how painful it is knowing how their relatives have been hurt and frightened.

Also, they want to be seen as partners, allowed to see their relatives and their relatives' rooms and involved in their lives

They want advocacy

They want their relatives to have interesting things to do each day

They want changes in the ways in which some staff have viewed and worked with their relatives

They want an end to the use of seclusion

They want information about how to make complaints

They want to be told about changes that are being made at the Hospital.

The Hospital staff want a clear picture of how nurses can support people with learning disabilities and autism

The Hospital staff want other ways of preventing people getting hurt and responding helpfully to those who have been hurt

Managers in Northern Ireland want a clear purpose for the Hospital and all services for people with learning disabilities and autism

Managers want well led services that have managers and staff who are respectful of people’s dignity and skilled in helping people to be valued and valuable citizens.

Today senior Trust staff met with families to discuss the findings and draft recommendations of the report commissioned by Belfast Trust into a Review of Safeguarding at Muckamore Abbey Hospital.

We want to place on record our sincere apologies to those patients and their families affected by staff behaviours which fell significantly below professional standards and were unacceptable.

An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the PSNI and Adult Safeguarding social workers.

We have taken decisive action, which included placing 13 members of staff on precautionary suspension. We are actively working on improving leadership and management arrangements at Muckamore Abbey Hospital, with the goal of ensuring that the voices of patients, family carers, advocates and others are clearly and effectively part of the future arrangements in Muckamore Abbey Hospital. A director oversight group led by the Director of Nursing and the Director of Adult, Social and Primary Care is in place.

Everyone has the right to be safe and free from harm. Safeguarding means having measures in place to protect human rights health and well-being, particularly for vulnerable people. In recognition of this, the Trust separately commissioned a fully independent team to undertake a review of the broader factors in Muckamore Abbey Hospital, to provide a clear picture as to what happened and to make recommendations on how to improve safeguarding.

The Review Team brought a wide range of experience perspectives and expertise as advocates, practitioners, clinicians, researchers and managers in service provision for people with learning disabilities and autism.

The findings of the Review Team highlighted that improvements are required in leadership and management, adult safeguarding approaches, advocacy, access to meaningful activities

for patients and physical health care. We fully accept all the findings and we will now work to ensure these are delivered.

The report strongly urges the Trust and the wider health, social care and housing organisations to re-double their efforts to ensure that patients do not have to live in hospital environments. It recommends patients are enabled to live full lives in the community, with access to the right specialist multi-disciplinary support in the right accommodation.

The key recommendations are:

- **No one should have to live their lives out in hospital – the report recommends a renewed commitment to enabling people with learning disabilities and autism to have full lives in their communities**
- **Deliver robust multi-disciplinary community services which recognise the full range of needs of people and families throughout their lives**
- **Assessment and treatment units closer to home and effective long term quality accommodation options**

We are committed to ensuring patients are cared for safely in Muckamore Abbey Hospital and we recognise and pay tribute to the many highly skilled and dedicated staff who remain working in Muckamore Abbey Hospital.

We wish to emphasise our commitment to openness and transparency to families and others in relation to sharing information appropriately. We are truly sorry that we have let our patients and their families down. Our priority now and in the future is to engage with the patients, families, staff, the DoH and the HSCB to deliver a future model of care for learning disability and autism.[1]

[1] BHSCT public statement 24 September 2018 https://belfasttrust.hscni.net/2018/09/24/muckamore-abbey-hospital-statement/

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MUCKAMORE ABBEY HOSPITAL

Trusts Action Plan

2018/2019

Thursday, 07 March 2019

IMPROVEMENT PLAN

Themes

1 Staffing

- Nursing Workforce Plan
- Management Of Historical CCTV
- Disciplinary Plan

2 Patients Physical Healthcare needs

- Patient Experience

3 Financial governance

4 Review Of Adult Safeguarding

5 Restrictive Practices

6 Hospital Governance

- Patient Safety Framework For The Measurement And Monitoring Of Safety

7 Regional Action/Discharge Relocation Planning

- Purpose Of Hospital
- Family Engagement
- Timely Discharge
- Rapid Development Of Statutory Supported Housing Scheme
- Development Of Community Services To Prevent Avoidable Admission And Provide Intensive Support For Placements

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Theme: 1 Staffing

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/ RAG
Ensure wards are safely staffed	Ensure rosters are planned in a timely and effective manner for all wards ensuring correct skill mix and number of staff allocated per shift meet patient's needs. Ward sisters or nurse in charge to escalate any changes in staffing needs to the lead nurse or on call nurse manager out of hours. Ward sisters will ensure the effective use of E-roster system Monitoring of nurse staffing levels daily by lead nurses and service manager Effective recruitment and retention strategies within Belfast and collectively with sister Trusts. Use of bank and agency support assistants and nursing staff (agency nurses will not be in charge)	Maintain safe staffing levels in line with agreed levels. Ensure minimum staffing levels are maintained 24/7. Daily oversight by lead nurses. Weekly review of rosters by service manager. Minimum levels achieved Beds downturned in PICU to enable safe staffing allocation 26WTE bank and permanent agency staff are currently deployed across MAH wards to ensure consistent effective cover	Director of Nursing Director of Nursing	For review end of March 2019 December 2019	

	Collaborative working with NHSCT and SEHSCT to support nurse staffing Absolute minimum of 2 registered nurses at all times Fortnightly reporting to Director Oversight Group in respect of Nursing staff utilisation Further development of the role of AHPs and behavioural specialist staff to support meaningful activities	Ward staffing allocation is overseen by lead nurses This is in development with the head of LD and head of psychology	Director Adult Social & Primary Care	Ongoing April 2019	
Development of a Regional workforce plan	Design interim nursing workforce model using Telford. Review of staffing needs being undertaken in line with a social care model with a view to preparation for discharge Work with the Delivering Care Group to design normative staffing levels for Learning Disability	Interim workforce plan developed and shared with PHA Initial discussion with Director of Nursing PHA in consideration of above To be confirmed by HSCB and DoH	Director of Nursing TBC	March 2019 March 2019 TBC	

Theme: 1 Staffing - Risk Management of Historical CCTV Reviewing and Decision Making

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME /RAG
• Complete 100% of historical CCTV initial viewing • Complete analysis of incidents reaching disciplinary threshold in line with agreed protocol (PICU to be completed by XXXX)	Validation exercise in process	Protective and safeguarding measures taken in respect of all CCTV viewing incidents to date in line with agreed protocol Hard drives transferred to Seapark to facilitate improved screen access and team working	Director Adult Social & Primary Care	No confirmed date for Seapark readiness using Antrim Road Police Station in the interim	
• Analysis team currently working through 158 incident analysis identified on 4th and 5th February 2019 for Cranfield 1 and 2 and Sixmile Assessment and Treatment	Revised protocol developed to reflect new context with PSNI • Initial screening to identify incidents • Analysis Teams Adult Safeguarding MAPA Line Management PSNI • Senior Decision Making Team to implement protection plans	• Initial screening work across 7 days to complete 100% viewing • Enhanced analysis teams work full-time with PSNI officers to complete analysis • Quality Assurance system for reviewing analysis put in place prior to interviewing	Director Adult Social & Primary Care	PICU completed by end of March 2019 All other wards to be completed by end of April 2019 (to be confirmed with PSNI)	

Thursday, 07 March 2019

Theme: 1 Staffing - Disciplinary Process

OBJECTIVES	ACTION	PROGESS	LEAD	TIMESCALE	OUTCOME/ RAG
Commence disciplinary proceedings for Phase 1 (PICU) in April 2019	Develop and populate HR GANTT chart of all HR tasks	Completed	Director of Human Resources	February 2019	
	Agree multi-professional process with management team, PSNI and Trade Unions	Ongoing		April 2019	
Appointment of two Independent disciplinary teams	Leadership Centre to commission two independent disciplinary teams (4 professionals)	Completed	Director of Human Resources	March 2019	

Theme: 1 Staffing - Staff Care

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/ RAG
To develop a comprehensive staff care service in recognition of the serious impact of the SAI on morale, well-being and resilience	– Full time counsellor in place	Achieved	Director Adult Social & Primary Care		
	– Occupational health clinic available on site	Review frequency	Director Adult Social & Primary Care	March 2019	
	– Keeping in touch system for absent staff	Review effectiveness	Director Adult Social & Primary Care	March 2019	
	– Development of psychological services strategy		Director Adult Social & Primary Care	March 2019	
	– Roll out of face to face stress assessment tool	Review progress	Director Adult Social & Primary Care	March 2019	
	– Meeting with Aisling Diamond to discuss	Meeting scheduled	Director Adult Social & Primary Care	March 2019	

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/ RAG
	alternative support system				

Theme: 2 - Patient Experience

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
Improve lived experience of people who are having an inpatient episode SAI recommendation	– Establish metrics in relation to LOS (length of stay)	Completed	Director Adult Social & Primary Care		
	– Implementation of day services review	Completed	Director Adult Social & Primary Care		
	– Implementation of My Activity Plan	Completed	Director Adult Social & Primary Care		
	– Decommission current Advocacy model	Completed	Director Adult Social & Primary Care		
	– Co-Produce new Advocacy model with families and implement	Underway	Director Adult Social & Primary Care	May 2019	
Physical Healthcare Needs	– Establish health care service & pathways (Population and acute)	Work has been undertaken to address the systematic barriers to improve access to healthcare screening Two off contract physicians and two physical healthcare nurses have been identified Action cancer scheduled to undertake breast screening	Director Adult Social & Primary Care	April 2019	

Theme: 3 - Finance Governance

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
To provide assurance of compliance in relation to the management of patients monies	Finance staff to work with ward staff to review procedures in relation to patients monies and to ensure these are adequate and fit for purpose Ward staff will be reminded of their responsibilities in relation to the management of patients monies	To be commenced	Director Adult Social & Primary Care	March 2019	

Theme: 4 - Review of Adult Safeguarding Practice in MAH

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
To review adult safeguarding practice in the hospital (DoH to initiate a review of safeguarding policy and procedures)	– Initial workshop facilitated by Margaret Flynn (18th February 2019)	Completed	Director Adult Social & Primary Care		
	– Development of a work plan	Underway	Director Adult Social & Primary Care	May 2019	
	– Appointment of Advanced Practice Adult Safeguarding Team	Underway	Director Adult Social & Primary Care	April 2019	

Theme: 5 - Review of restrictive Practices

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
Review of Restrictive Practice Policy	Policy reviewed in line with RC guidance to be issued for consultation with families, staff and other stake holders	Seclusion episodes have been reducing from 745 in 2015 to 158. A further 102 in patients own room (self-requested)	Director Adult Social & Primary Care	March 2019	
- Future Care Safe - Responding and Improving	Daily hospital huddle Hospital pause Core Bundles PIPA model Further increase in ATTP and Psychology Patient experience measures	Commenced Commenced In planning In planning In planning	Director Adult Social & Primary Care	June 2019	

Theme: 6 – Hospital Governance

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
Develop and Implement safety measurement and monitoring Framework Past care R & I Reliability M & M Future Care	Key safety metrics Safety Metrics Monitored weekly • Seclusion episodes • Incident analysis • Staff levels • AS referrals/issues • Medications • Physical interventions • Rapid tranquilisation • Staff injuries	Dedicated data analytics post to be put in place to support and develop framework	Director Adult Social & Primary Care	May 2019	

Thursday, 07 March 2019

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
Safe Safe today	• Complaints • Compliments				
Implement patient safety systems and processes	• Daily safety briefings each ward • Live CCTV implemented – policy updated • Positive Behaviour Support Nurses each ward • Psychological formulations each patient • Clinical RA every patient • Weekly consultant led MD Meetings • Weekly live governance meetings led by CD/CofD • Roster Management • Safety workarounds • Ward sisters/CN Meetings • Service Manager meetings with operational managers • Contemporaneous viewing	Implemented		Ongoing	

Thursday, 07 March 2019

Theme: 7 - Regional Action/Discharge Relocation Planning - Purpose of Hospital

OBJECTIVES	ACTION	PROGRESS	LEAD	TIMESCALE	OUTCOME/RAG
To return Muckamore Abbey Hospital to an acute assessment and treatment unit Permanent Secretary Commitment	- Prevention of avoidable admissions	Inter-trust project to process map and agree protocol Previous pattern of admission was average 10 p/m now reduced to 7p/m	Directors HSCB (TBC)	Sept 2018	
	- Ensure full MDT are ward based. Enhance MDTs	Additional staff appointed; Social Work Pharmacist AHP	Director Adult Social & Primary Care	Completed	
		Pharmacy technician psychology	Director Adult Social & Primary Care	April 2019	
	- Psychological formulations for all patients	Completed	Director Adult Social & Primary Care	Completed	
	- Implementation positive behaviour support on all wards	B5 staff appointed to all wards	Director Adult Social & Primary Care	Completed	
	- Appointment of Service Improvement lead for MAH	Interviews scheduled	Director Adult Social & Primary Care	May 2019	

Thursday, 07 March 2019

The **Regulation** and **Quality Improvement Authority**

Assurance, Challenge and Improvement in Health and Social Care

Our ref: IN000003 / IN000004 / IN000005

16 August 2019

Private and Confidential

Mr Martin Dillon
Chief Executive
Belfast Health and Social Care Trust
Trust Headquarters
Belfast City Hospital
51 Lisburn Road
BELFAST
BT9 7AB

Dear Mr Dillon

Improvement Notices

Belfast Health and Social Care Trust, Muckamore Abbey Hospital (RQIA ID: 020426)

IN Ref: IN000003 / IN000004 / IN000005

With reference to our intention to serve four Improvement Notices in respect of failure to comply with the minimum standards, detailed in our correspondence of 7 August 2019.

Having reviewed and considered the findings of our inspections, additional intelligence received following our inspections and discussions with senior Trust representatives at meetings on 7 March 2019 and 14 August 2019, we have made the following determinations.

With respect to restrictive practices (seclusion) the Trust's response has been constructive, we discussed this area in detail during our meeting on 14 August 2019. We note the work in progress and planned over coming weeks under the guidance and expertise of Dr Joanne Dougherty. We have determined not to serve an Improvement Notice relating to this area at this time. We would encourage you to ensure that Dr Dougherty continues to receive all necessary support to enable full implementation of the Trust's refreshed policy and practices relating to seclusion. We will continue to monitor the trust's progress in relation to this area.

We recognise that the Trust is working to address concerns we have identified in relation to the staffing model, financial governance and safeguarding practices at Muckamore Abbey Hospital. Work is ongoing in some areas and has commenced in other areas. It is our view that a continued commitment to progress the work as outlined by senior Trust representatives, and to co-ordinate the many aspects of the work in progress and planned, will support the Trust to achieve compliance with the relevant standards.

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In accordance with Article 39 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, we have determined we will serve three Improvement Notices in respect of a failure to comply with the following standards:

The quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

RQIA requires that the necessary improvements outlined in the attached Improvement Notices are implemented by you within the advised timescales, in order to ensure full compliance with these standards. Should you decide that compliance with improvements outlined in these Improvement Notices has been achieved before the due date, you should inform us and we will consider this information.

You may make formal representation to RQIA with regard to these Improvement Notices by writing to the Chief Executive, using the template provided, within one calendar month of receipt of the notice, stating the precise reasons for making the representation.

You are deemed to have received these Improvement Notices on the next working day after the date of posting or on the day you received this correspondence by electronic delivery.

A copy of the Improvement Notices will be forwarded to all relevant stakeholders and RQIA's Communication Manager on the day of issue, for posting on the enforcement pages on RQIA's website www.rqia.org.uk

Once compliance has been achieved, the relevant Improvement Notices will be removed from our 'Current Enforcement Activity' webpage and a clear statement of compliance with the relevant notices will be placed on our website. We will retain a record of past enforcement activity, in line with our established retention schedules.

If you require any further information regarding this correspondence please contact Lynn Long, Assistant Director, Improvement Directorate, on 028 9536 1918.

Yours sincerely

Olive Macleod OBE
Chief Executive

Enc

cc Dr Lourda Geoghegan, Director of Improvement and Medical Director
Lynn Long, Assistant Director

Unannounced Enforcement Inspection Report
10, 11 & 12 December 2019

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

www.rqia.org.uk
Assurance, Challenge and Improvement in Health and Social Care

Membership of the Inspection Team

Dr Lourda Geoghegan	Director of Improvement and Medical Director, Regulation and Quality Improvement Authority
Lynn Long	Assistant Director, Regulation and Quality Improvement Authority
Dr John Simpson	Medical Peer Reviewer, Regulation and Quality Improvement Authority
Alan Guthrie	Senior Inspector (Acting), Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Stephen O'Connor	Inspector, Independent Healthcare Team, Regulation and Quality Improvement Authority
Norma Munn	Inspector, Independent Healthcare Team, Regulation and Quality Improvement Authority
Joseph McRandle	Inspector, Finance Team, Regulation and Quality Improvement Authority
Dr Stuart Brown	ADEPT Fellow, Regulation and Quality Improvement Authority
Paulina Spychalska	Inspection Coordinator, Regulation and Quality Improvement Authority
Gary McMaster	Inspection Coordinator, Regulation and Quality Improvement Authority

Abbreviations

BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
CCTV	Closed Circuit Television
DFC	Department for Communities
DAPO	Designated Adult Protection Officer
DoH	Department of Health
GP	General Practitioner
IN	Improvement Notice
MAH	Muckamore Abbey Hospital
MAPA	Management of Actual or Potential Aggression
MDT	Multi-disciplinary Team
MHO	Mental Health (Northern Ireland) Order 1986
NHS	National Health Service
NHSCT	Northern Health and Social Care Trust
NIASP	Northern Ireland Adult Safeguarding Partnership
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
PIpA	Purposeful Inpatient Admission
PRN	pro re nata "as needed"
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SEHSCT	South Eastern Health and Social Care Trust
SEA	Significant Event Audit
SMT	Senior Management Team
SITREP	Situation Report

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). There were 83 beds in the hospital at the time of the inspection. The Psychiatric Intensive Care Unit (PICU) temporarily closed on 21 December 2018 and has remained closed since that date.

At the time of the inspection there were five wards operational on the MAH site:

- Cranfield One (male assessment)
- Cranfield Two (male treatment)
- Ardmore (female assessment and treatment)
- Six Mile (forensic male assessment and treatment)
- Erne (long stay/re-settlement).

A hospital day care service was also available for patients.

During the inspection there were 53 patients receiving care and treatment in MAH.

3.0 Service details

Responsible person: Mr Martin Dillon	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Bernie Owens, Director Neurosciences, Radiology and Muckamore Abbey Hospital, BHSCT	

4.0 Inspection summary

We undertook an unannounced inspection to MAH over three days commencing on 10 December 2019 and concluding 12 December 2019. Five wards were inspected over the course of the inspection which included a night time inspection on 11 December 2019 from 03:00 – 04:00 of all wards.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

On 16 August 2019 RQIA issued three Improvement Notices (INs) to MAH in respect to a failure to comply with minimum standards. This inspection sought to assess the level of compliance achieved in relation to the Improvement Notices. The areas identified for improvement and compliance were:

- IN000003 - management of staffing levels
- IN000004 - governance of patients' finances; and
- IN000005 - adult safeguarding arrangements.

The date by which compliance with the Improvement Notices must be achieved was 16 November 2019.

We found sufficient evidence to validate full compliance with Improvement Notice - IN000003 relating to the management of staffing levels.

We found evidence of improvement and acknowledge that progress had been made to address the required actions within the other two Improvement Notices, IN000004 relating to the governance of patients' finances and IN000005 relating to adult safeguarding arrangements. However, we did not find sufficient evidence to validate full compliance with these two Notices.

RQIA senior management held a meeting on 13 December 2019 and a decision was made that the date of compliance for Improvement Notices IN000004 and IN00005 should be extended. Compliance with these Notices must therefore be achieved by 19 March 2020. The extended Improvement Notices – IN000004E and IN000005E were issued on 19 December 2019.

We had previously raised serious concerns and identified areas for improvement during inspections in February and April 2019 in relation to restrictive practices (seclusion) and the management of patients' physical health needs. The Trust submitted information following the April inspection to provide assurance in relation the progress made to address these concerns and we also used the information provided as part of this inspection. We found that significant improvements had been made and the two areas for improvement had been fully addressed.

We reviewed an additional five areas for improvement that were made following the previous inspection in April 2019 which related to CCTV policy and procedures; the management of patients' observations; discharge planning; strategic governance; and hospital governance. We were able to evidence that sufficient progress had been made to fully address four of the areas for improvement, however, the area for improvement relating to CCTV policies and procedures was only partially met and has been stated for a third time.

One area for improvement in relation to medicines management was not reviewed as part of this inspection and is carried forward to the next inspection.

4.1 Inspection outcome

Total number of areas for improvement	6

Total number of Improvement Notices	2 (Extended)

There are six areas for improvement arising from this inspection, comprising of four new areas for improvement. The four new areas of improvement relate to developing and implementing a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks; implementing a system of assurance in respect of delivery of physical health checks; reviewing the hospital's need to provide a seclusion room; and outlining a statement of purpose for the use of the "Low Stimulus Area".

One area for improvement in relation to medicines management identified during our inspection in February 2019 was not reviewed during this inspection and will be carried forward for review at a subsequent inspection. One area for improvement in relation to CCTV was assessed as only partially met and has been stated for a third time.

Ongoing enforcement action resulted from the findings of this inspection. As a result of this inspection the date of compliance with two Improvement Notices, IN000004 and IN000005 was extended to 19 March 2020.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Improvement Notices for Health and Social Care Trusts are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children services.

Details of the inspections findings and QIP were discussed with MAH SMT on16 December 2019.

5.0 How we inspect

Prior to the inspection, we had a meeting with the MAH Senior Management Team (SMT) on 2 November 2019 in the office of RQIA. At this meeting the SMT presented the actions they had taken to address the improvements necessary in relation to restrictive practices and the management of staffing levels as set out in the Improvement Notice IN000003. We tested the information they provided during this inspection. We also reviewed a range of information relevant to the service including the following records:

- previous inspection reports;
- Serious Adverse Incident (SAI) notifications;
- written and verbal information received following the previous care inspection in April 2019 and the previous finance inspection in July 2019;
- adult safeguarding referrals; and
- complaints received by RQIA.

We assessed each ward using a standardised inspection framework. The methodology underpinning our inspections included; discussions with patients; observations of practice; interviews with staff; and a review of relevant documentation. We examined samples of records during the inspection which included: nursing care records; medical records; SMT and governance reports; minutes of meetings; duty rotas; and staff training records.

Posters informing patients, staff and visitors of our inspection were displayed while our inspection was in process.

We invited staff to complete an electronic questionnaire during the inspection. We did not receive any returned completed staff questionnaires following this inspection.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 15-16 April 2019

Areas for improvement from the previous inspection 15-16 April 2019		
Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: 2. a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 3. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	**Partially Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as partially met and has been stated for the third time, further detail is provided in section 6.3.1.	
Area for Improvement 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in with	**Met**

	best practice guidelines.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met due to the substantial process made by the Trust to address these matters, however, a further area for improvement was made in respect of the environment used for seclusion and further detail is provided in section 6.3.2.	
Area for Improvement 3 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.4.	
Area for Improvement 4 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	**Carried forward to the next inspection**

<table>
<tr><td></td><td>Action taken as confirmed during the inspection:
Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection.</td><td></td></tr>
<tr><td rowspan="2">Area for Improvement 5

Ref: Standard 5.1
Criteria 5.3 (5.3.1)

Stated: Second time</td><td>The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to:

1. Ensure that there is an appropriate number of qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes.
2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy.
3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH.
4. A system of assurance in respect of delivery of physical healthcare.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met and further detail is provided in section 6.3.5.</td></tr>
<tr><td rowspan="2">Area for Improvement 6

Ref: Standard 5.1
Criteria 5.3 (5.3.3 (b)

Stated: Second time</td><td>The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met and further detail is provided in section 6.3.6.</td></tr>
<tr><td>Area for improvement 7

Ref: Standards 4.1 & 8.1
Criteria 4.3 (b, d and e), 8.3 (b)

Stated: Second time</td><td>The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning:

1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff.
2. Ensure that stated aims and objectives for the hospital's PICU are developed and</td><td>Met</td></tr>
</table>

	disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.7.	
Area for Improvement 8 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met and further detail is provided in section 6.3.8.	

6.2 Inspection findings

Improvement Notice Ref: IN000003

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS

4.3 Criteria

The organisation:

(i) undertakes systematic risk assessment and risk management of all areas of its work;

(j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

(n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(f) Has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: protection of health, welfare and safety of staff.

5.3.3 Promoting Effective Care

The organisation:

(c) *promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;*
(d) *ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems.*

In relation to this notice the following four actions were required to comply with the standards.

The BHSCT, Chief Executive, and Executive Team must:

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

a) is based on the assessed needs of the current patient population; and
b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

2. Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of the current staffing model and associated escalation measures.

4. Engage the support of, and work in partnership with, other HSC organisations (including the Health and Social Care Board, the Public Health Agency and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability in-patient services / wards. The design and testing of future staffing models must be supported by appropriate assurance processes and tools.

6.2.1 Staffing

We gathered evidence in relation to the four action points contained within the Improvement Notice IN000003, to establish if the BHSCT, Chief Executive, and Executive Team had complied with the minimum standard and developed a model that would ensure nurse staffing at ward level and across the MAH site was planned and managed on the basis of assessed patient need. We established the following in relation to each action:

<u>Action Point 1</u>

The Belfast Health and Social Care Trust, Chief Executive, and the Executive Team must:

1. *Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:*

a) is based on the assessed needs of the current patient population; and
b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

Prior to the inspection we met with the SMT from BHSCT on 2 November 2019 in our offices. At this meeting the SMT presented to us a revised staffing model which incorporated the Telford model for calculating registered staff numbers. They informed us that the model was based on the assessed needs of the patient population in MAH, was patient centred, flexible and adaptable enough to meet the changing needs of the patients in the hospital. The model also enabled management to ensure that the skill mix of staff in each ward was appropriate to deliver the required care for patients.

During the inspection we visited the five wards and reviewed the implementation of the revised staffing model by reviewing staffing levels, skill mix and the assessed needs of patients on the each ward. We found the model had been implemented effectively and staffing levels were appropriate to meet the needs of patients on each ward. Staff reported to us that they were involved in the development of the model and this had helped raise staff morale. Staff told us that while delivering on the proposed skill mix does not always happen on every ward on every day, the numbers of staff required for each ward is as close as possible to the numbers required to meet the patients assessed needs. Staff told us that staffing levels had significantly improved since our last inspection.

Outcome of action point 1

We were assured by discussion with the SMT; review of documentation; discussion with staff; and review of rotas and skill mix in relation to assessed needs of patients that sufficient progress had been made to address the staffing levels in MAH. This action point has been addressed.

Action point 2

2. *The Belfast Health and Social Care Trust, Chief Executive, and the Executive Team must:*

   Implement an effective process for oversight and escalation of challenges relating to staffing across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

Prior to the inspection the SMT informed us during the meeting on 2 November 2019, that a process had been implemented to ensure that senior staff were available 24 hours every day to support ward staff to escalate challenges relating to staffing levels; this included ward managers, lead nurses and members of the SMT. We were informed that both the operational and executive team have oversight staffing levels to ensure that they are safe.

During the inspection we reviewed the process in place for oversight and escalation of challenges relating to staffing levels. We found the role of the night time co-ordinator had been developed to include an oversight of staffing arrangements on each ward for each day to ensure that the staffing levels and skill mix met the assessed needs of patients on each ward. A report was produced by the night time co-ordinator each morning for the SMT to review.

We were informed communication had improved significantly across the site between wards and members of the SMT. We found that mechanisms were in place to ensure that relevant staff were informed well in advance (every month) and kept up to date regarding the availability of senior and medical staff for out of hours cover. Staff told us that incidents of staff shortages were responded to in a timely way.

We were informed that the same agency staff were generally booked for a block of shifts which provided consistency of care for patients and stability across the hospital. We found that agency staff were now more embedded into the overall staff team and it was reported that wearing the BHSCT uniform had helped with this integration process. The SMT told us that this had also helped patients understand that agency staff and trust employees were all part of the same team and all staff were equally responsible for ensuring the provision of their care. We established that agency staff undertake a rigorous induction programme which is delivered at Trust, site and ward level. We reviewed these induction programmes and determined that they were robust and covered all key areas.

We were informed that there has been a policy change in the Trust that enables agency staff who have worked on the site for some time to now take charge of a ward. A comprehensive and supportive framework was designed to ensure agency staff are assessed as competent in all the challenges that may arise when taking charge of a ward. Agency staff are signed off after completing each phase of the framework by the ward manager and night time coordinator. We reviewed one of these assessment frameworks and were satisfied that the assessment process was robust. Ward managers told us that agency staff being able to take charge of the ward had been invaluable. It had enabled senior ward staff to attend a variety of meetings which helped in progressing various pieces of quality improvement work and had contributed to the overall increase in staff morale.

Across all wards, managers, deputy managers, nurses, doctors and nursing assistants informed us that there was a more visible presence of members of the SMT. Staff who spoke with us were knowledgeable regarding which members of the SMT were responsible for the oversight of individual wards and particular pieces of work. Staff reported to us that members of the SMT are approachable and supportive. Staff told us that they felt empowered to share their concerns with SMT and believed that their concerns were heard and considered. Both front line staff and the SMT informed us that they welcomed the increased numbers of senior staff as this provided the required capacity to address any emerging challenges and issues identified.

We found that each week a designated member of the SMT produced a report that illustrated the percentage of shifts filled for each ward. This information along with the Situation Report (SITREP) was shared fortnightly with the ward managers across the hospital. Ward managers informed us that these reports coupled with the weekly safety brief and live governance meetings had been instrumental in helping each ward recognise and understand the pressures that other wards experienced at times across the hospital. This increased level of understanding by Ward Managers and staff, through the sharing of written data and reports, had contributed to a genuine desire in the staff to assist other wards during challenging periods. We were advised that there was also a shared understanding between the wards that this level of support will be reciprocated when required.

Ward staff informed us that all staff had the option to self-refer to the on-site staff counsellor and were offered the option of having counselling sessions on or off the hospital site, if they required additional support. Staff told us that reflective practice sessions are scheduled on a weekly basis and they considered the counselling and reflective practice sessions supportive.

Through discussion, we confirmed that all ward managers were aware of staff on their ward that were subject to a protection plan and/or supervision plan. These plans were in place to protect patients and staff while investigations of specific allegations remain ongoing.

During our previous inspections we identified that behaviour nurse specialists were subsumed into the staffing compliment of each ward and did not have protected time to review or devise positive behaviour support plans for patients.

Staff who spoke with us reported that the behaviour nurse specialists are no longer subsumed into the overall staffing compliment thus are able to focus on their original role. This has been beneficial for staff and patients because bespoke positive behaviour support plans are now in place and being actioned. We found that a new behaviour support assistant role had been created and assigned to each ward. Staff reported that this new role had a positive effect and was benefitting the overall patient experience. The behaviour support service is managed through the psychology department.

We established that each ward had a schedule of evening and weekend activities for patients to participate in. A number of art, music, beauty and specialist therapists visit the hospital to provide activities. Some of these are specific to patients, wards or provided as group activities. Staff reported that patients were now more engaged in meaningful activities which had reduced boredom leading to a decrease in incidents of aggression and assaults on staff. Although incidents of aggression and assaults can still occur, staff told us that the reduction had helped improve staff morale and reduced sickness and absenteeism.

Some staff who spoke with us advised that they had appreciated the opportunity to participate in the learning exchange programme with a Trust based in the UK. A team of multi-disciplinary professionals from MAH visited another Trust's low-secure ward for patients with learning disabilities and MAH agreed to host to an exchange visit. Staff reported that they found this opportunity invaluable and inspiring. They were able to see and experience how the other learning disability inpatient service managed similar challenges they were facing. Staff expressed that they would be keen for this learning exchange programme to continue as they could see the benefits for staff participating in this ongoing educational and shared learning environment.

We were advised that the hospital was facing an on-going challenge in relation to retaining and recruiting nurses and other staff. However there was a consensus among staff that the current SMT had made positive strides in stabilising the site; listening, responding to and acting on staff concerns; improving communication; being visible and approachable to staff; raising confidence; and re-establishing pride within the learning disability nursing profession in the hospital.

Outcome of action point 2

We found sufficient evidence to determine that this action point has been addressed.

Conclusion

We found sufficient evidence to validate that BHSCT had made the necessary improvements to achieve compliance with the Improvement Notice – IN000003.

Improvement Notice Ref: IN000004

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

4.3 Criteria

The organisation:

(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;
(g) has systems in place to ensure compliance with relevant legislative requirements;
(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;
(i) undertakes systematic risk assessment and risk management of all areas of its work.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

In relation to this notice the following four actions were required to comply with the standards.

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

a) that appropriate records of patients' property are maintained;

b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

c) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

6.2.2 Financial Governance

Action point 1

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

1. That the Trust is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

At the last inspection on 1 July 2019 we reviewed the draft policy in relation to the management of patients' monies and valuables. We identified several weaknesses within the policy and determined it was insufficient to ensure that the Trust met with all its responsibilities under the Mental Health (Northern Ireland) Order 1986. Through speaking we staff we identified that discussions with ward managers had commenced for the purpose of familiarising staff with the revisions of the policy however this did not constitute staff training.

We were advised, during this inspection, that the Patients' Finances and Private Property – Policy for Inpatients within Mental Health and Learning Disability Hospitals had been revised and implemented. The policy was used to form part of the training programme provided to members of staff in each ward. We reviewed the policy and determined it to be satisfactory.

We found evidence that staff were adhering to the new policies and procedures implemented by the Trust. We were informed that due to feedback from staff further revisions were being made to the policy and the Trust intends to implement the changes by January 2020.

Outcome of action point 1

We found sufficient evidence to determine that this action point has been addressed.

Action point 2

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

2. In respect of those patients in receipt of benefits for whom the Trust is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.

We were shown evidence that the Trust had contacted the Department for Communities (DFC) requesting written confirmation that the Trust was the authorised appointee for the thirteen patients identified at previous RQIA inspections in April 2019 and July 2019 and that the patients were receiving the correct benefits owed to them. We reviewed the written replies from the DFC which confirmed that the Trust was the patients' appointee and that the patients were receiving the correct benefits. We noted that DFC also confirmed if patients had been over or under paid benefits during the period the Trust was the appointee. Discussions with the Trust and a review of records confirmed that one patient had been overpaid benefits for almost six years, however, as the Trust had notified the DFC at the time when the financial circumstances for the patient had changed, the DFC deemed the overpayment was non-recoverable.

We were informed that in addition to confirming appointeeship the Trust had entered into discussions with an external advisory organisation to provide advice to patients and their families in relation to managing their finances. This included ensuring that patients were receiving the full amount of social security benefits owed to them. At the time of our inspection the Trust was in the final stages of contracting with the independent advisor.

Outcome of action point 2

We found sufficient evidence to determine that this action point has been addressed.

Action point 3

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and Trust's policy and procedures; this includes:

e) that appropriate records of patients' property are maintained;

f) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role;

g) that audits by senior managers of records retained at ward level are completed in accordance with Trust policy;

h) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

We were informed that a patient liaison officer had been appointed by the Trust and part of their duties was to coordinate monthly audits of patients' monies and liaise with patients' family members.

We were advised that financial planning meetings had been implemented since the previous RQIA inspection in July 2019. Review of records from the meetings showed that a member of the MDT from the Trust met with patients' family members to discuss the spending plan for patients with significant finances. There was evidence that the Trust was in regular contact with family members to provide updates on the planning process and to seek agreement for the planned expenditure from patients' monies. We found there was also evidence of the decisions made by the MDT in relation to financial matters for patients who had no next of kin.

We evidenced that members of staff within each ward had received training in relation to the handling of patients' monies. The records we reviewed showed the dates members of staff received the training and we were provided with a copy of the training programme provided to staff. We noted that in addition to the training provided by the Trust, training was also provided by the Directorate of Legal Services from the Business Services Organisation (BSO). This included an overview of the responsibilities for being a patient's appointee and other protective measures in place for safeguarding patients' finances.

We noticed a significant improvement within each ward in relation to the recording of transactions undertaken by members of staff on behalf of patients.

Following the finance inspection in July 2019 a new system for recording financial transactions was implemented by the Trust. We sampled a number of patients' records within each ward and evidenced that the full details of the transactions were recorded; two signatures were recorded against each of the transactions; good practice was observed as the amounts deducted to make the purchases and the remaining monies returned from the purchases were recorded separately; and receipts from the transactions were retained for inspection. A record of patients' personal property held for safekeeping within each ward was also found to up to date. We confirmed that in line with good practice, records of patients' monies and property held for safekeeping were checked on a weekly basis and signed by two members of staff.

We found that additional monthly checks of patients' monies held within each ward were undertaken by the assistant service managers. Records of the checks showed that any discrepancies were identified and addressed by the Trust immediately. We were informed that the outcomes of the findings from the monthly checks were discussed at the monthly governance meetings and any learning or actions required was disseminated among members of staff at ward level.

We found that patients' personal property held for safekeeping within the wards was not included in the monthly checks by the assistant service managers. We discussed this finding with the Trust and highlighted the benefits of including a review of patients' personal property in the monthly checks and future governance meetings.

We were provided with a copy of an audit assignment plan from the Internal Audit Service at BSO to audit the management of property and monies by the BHSCT on behalf of patients within MAH. The plan identified the scope of the audit to be undertaken and the planned date of commencement for the audit was 20 January 2020, however, we were informed that the audit may be delayed until February 2020.

Outcome of action point 3

As the audit of financial controls by the Internal Audit Service had not taken place by the time of this inspection we were unable to gather sufficient evidence to determine that this action point had been fully addressed.

Conclusion

We acknowledged the actions taken by BHSCT to achieve compliance with the minimum standards and the significant improvements made since the last finance inspection. However, as the audit of all financial controls has yet to take place, the improvement notice IN000004 was extended to 19 March 2020 to allow time for the findings from the BSO audit to be reviewed by the Trust and RQIA.

Improvement Notice Ref: IN000005

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;
(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

In relation to this notice the following three actions were required to comply with the standards.

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must:

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, Trust senior managers and / or the Executive team as appropriate.

3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.

6.2.3 Safeguarding

Action point 1

1. Implement effective arrangements for adult safeguarding at Muckamore Abbey Hospital and ensure:

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;

b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;

c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;

d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding is improved.

We were informed that staff had received training in adult safeguarding. Staff who spoke with us demonstrated a good awareness of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified; including the need to make timely referrals. We found on that the training matrix for each ward evidenced that not all staff had received safeguarding training and there was no evidence to confirm the individual levels of training staff had received were in accordance with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016).

The Adult Safeguarding Lead for the hospital was aware of the deficit and informed us that they planned to be more involved in ensuring that training was up to date and provided to the correct level. We were further assured from our discussions with SMT that they were also aware of the gaps in safeguarding training and had made plans to address it.

We spoke with staff of different grades (including agency staff) and were satisfied that staff had a clear understanding of the process for making safeguarding referrals and their individual roles and responsibilities. From review of the care records, we evidenced that timely referrals were being made.

We were informed that all wards had access to copies of the BHSCT Safeguarding Policy, the regional Adult Safeguarding Prevention and Protection in Partnership policy (July 2015) and Adult Safeguarding Operational Procedures (2016) and these were easily accessible to staff. We observed that flow charts were displayed on each ward which provided guidance to staff about the process of referral to the Adult Safeguarding Team and on how to escalate concerns to the SMT.

We found that all wards had folders containing interim protection plans and MDT protection plans for patients. Samples of protection plans were reviewed and all were found to be appropriate, meaningful and corresponded to information contained in the patient’s care plans and care records.

We evidenced that safeguarding incidents and referrals were being discussed at the daily safety brief and at some of the Purposeful Inpatient Admission (PipA) meetings. The Purposeful Inpatient Admission (PIpA) model was introduced by the Trust which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment.

We observed that the protection plans are standardised throughout the hospital which enables staff to be quickly updated following a period of leave or when required to work in another ward at short notice.

Staff were aware of their responsibilities to be familiar with the content of the plans. Staff reported that having this information stored in one file, ensures they can quickly be updated with regards to the specific protection plans within each ward therefore maintaining the patients' safety. Staff spoke positively to us about the introduction of this process and can see its benefit. Staff were aware of the procedures around trigger points for a referral to safeguarding.

In relation to staff supervision plans, we found that ward managers had a good knowledge of which staff were subject to supervision plans and had a good understanding of what was required in relation to implementing the plans. This demonstrated a good balance between maintaining the appropriate supervision requirements and providing confidentiality, respect and support for those staff involved.

We examined care records and evidenced that family members and relevant professionals were being updated about safeguarding concerns in a timely manner. There was appropriate referral to PSNI and communication with RQIA when required. We found timely screening of safeguarding referrals at ward level and we were assured that the Designated Adult Protection Officers (DAPOs) had oversight of all referrals made, even the ones that had been screened out at ward level, which provided an additional level of scrutiny.

We noted an improved awareness of safeguarding generally throughout the hospital which was driven by discussion of safeguarding concerns at PIpA meetings, live governance meetings and daily safety briefs. We were told about the improved working relationships across disciplines by staff who reported feeling supported by the safeguarding team. We were informed that there are now weekly safeguarding MDT meetings on most wards. Staff reported a greater presence on the wards of the safeguarding team and felt confident in contacting the team outside of the planned meetings for advice and support. We were told that at the weekly meetings all new safeguarding referrals and interim protection plans were discussed and protection plans were formalised collaboratively. Existing safeguarding cases were reviewed and protection plans were updated as required. Staff who spoke with us knew the names of the relevant safeguarding personnel and how to contact them.

We spoke with the Adult Safeguarding Lead for the hospital and saw evidence of the monthly audit of the screening of safeguarding incidents which enabled trend analysis. This information was shared with the SMT and provided assurance of safeguarding oversight at this level. We were informed that the Adult Safeguarding Lead and the DAPOs meet weekly to discuss any concerns and a new Adult Safeguarding Forum is planned to commence which will allow for discussion of safeguarding cases and will serve to further improve and share learning outcomes.

We observed the complex nature of some of the patient behavioural challenges presented to staff. As previously discussed, staff reported to us the benefits of the increased activities for patients and the positive effect this had on individual behaviours.

A review of safeguarding incidents by the Trust found that many were due to clashes between patients or patients not having a sense of their own personal space. As a result of this review, ward environments had been creatively reconfigured to provide extra personal space for some patients to the extent that self-contained apartment type "pods" had been created. This had contributed positively to the overall safeguarding of patients and staff reported feeling supported by the current SMT in relation to safeguarding.

Outcome of action point 1

We were able to evidence that improvements had been made to address this action point.

Conclusion

We were able to evidence that the BHSCT had made significant improvements to achieve compliance with the minimum standards dictated within IN000005. However, in order to be assured that these improvements have been embedded into practice the notice will be extended until 19 March 2020 to provide time for such sustained assurance to be gained.

6.3 Review of areas for improvement from previous inspections

6.3.1 Close Circuit Television (CCTV)

We reviewed the arrangements in relation to the oversight and governance for the use CCTV within the hospital. We found that there was an effective process in place for contemporaneous monitoring and managing of CCTV images. We were informed by the SMT that monitoring of CCTV was undertaken by a MDT team and was used to demonstrate and share good practices with staff. It was also used as a mechanism for sharing learning outcomes and directing improvements.

Staff told us they understood the procedures to be followed in regards to CCTV and were able to describe the process for CCTV viewing after an incident. Some staff told us that they were fearful of the CCTV monitoring and shared with us their lack of ownership and understanding regarding the use of CCTV and some felt that it was not supporting them in their work.

We were advised that consideration is being given to how best to utilise the current CCTV footage as a learning tool to enhance quality improvement in the Management of Actual or Potential Aggression (MAPA) and related matters to obtain a better insight of events when screening safeguarding incidents.

We were advised that the hospital's CCTV policy and procedural guidance had been reviewed by the SMT; however, they had not updated the documents as they were waiting for the publication of national guidelines. We reviewed the policy and found that it did not reflect the current multiple uses for CCTV at MAH. As highlighted at previous inspections, this policy must be reviewed and updated to reflect current practice as it is used to inform and direct staff in relation to use of CCTV across the hospital.

We acknowledge that progress had been made in relation to the arrangements for the management and monitoring of CCTV, however further work was needed in relation to the CCTV policy and procedure; embedding the new practices; staff understanding the purpose and benefits of CCTV at MAH. An area for improvement in relation to CCTV has been stated for the third time.

6.3.2 Restrictive Practices (Seclusion)

Prior to this inspection we held a meeting with the MAH SMT at RQIA offices on 2 November 2019. At this meeting the SMT presented improvements they had made in relation to the use of restrictive practices. We tested the information provided at the meeting during this inspection.

We reviewed the use of restrictive practices including seclusion at MAH and found evidence of continued reduction and improvement in relation to the use of these practices. We noted the hospital's seclusion policy and procedure had been reviewed and updated.

We found the Trust had introduced an effective strong governance and assurance framework in relation to the use of seclusion. Restrictive practices were routinely audited and reported through the BHSCT assurance framework. We observed that restrictive practices were reviewed at ward level; by the MDT; at Live Governance meetings; by the SMT and also system wide by the MAH Directors Operational Group; by the Executive Team; and bi-monthly at the Trust Board meetings.

We found the Trust had developed and implemented a restrictive practice strategy and was continuing to embed a positive behavioural support culture and practice across the hospital. As previously discussed, behaviour assistants had been recruited and patients with the most challenging behaviours had a positive behaviour support plan in place and the Purposeful Inpatient Admission (PIpA) model was introduced. There was evidence that low stimulus areas were used as a means of deescalating behaviours rather than using seclusion.

We found the use of seclusion had significantly reduced across the site. In September 2019 we established there was a total of 23 seclusion events across the hospital site and we contrasted this with the previous year and found that there had been 120 seclusion events in September 2018. The number of seclusion events had further reduced to 10 in October 2019. We noted that seclusion events in September and October 2019 lasted less than four hours. We examined the audits in relation to the use of seclusion events during this period and found good compliance with the recording of seclusion events in line with the Trust's policy and procedure, the required standards and best practice. We were told about plans to perform a robust audit within the next twelve months in relation to the use of PRN medications to ensure that other forms of restrictive practice were not emerging.

We found good evidence in patient care plans of the decision making process relating to the use of restrictive practices including the use of seclusion. Staff told us that morale had improved, with staff feeling that they now have a better perspective and involvement in decision making on the use of restrictive practices. We found the need for the use of restrictive practices was continually discussed at patients' MDT meetings and during weekly MAH live governance meetings. We found that a report of contemporaneous CCTV viewing is also being produced and reported at governance meetings. It was good to note that the hospital had introduced a strong governance and assurance framework in relation to the use of seclusion and that this practice was being well led.

We observed that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) were being supported through structured debriefing and were being provided with the opportunity to discuss incidents. The introduction of the PIpA model was providing opportunities to identify and share learning with greater frequency and in a more timely way so that if changes to patients care plans were required this could be done quickly and with MDT input.

It was encouraging to note that ward managers across the hospital continued to closely monitor staff training including training in relation to the use of restrictive practices. Training records reviewed by us detailed that approximately 95% staff had completed up to date MAPA training. The remaining 5% had been scheduled to complete retraining in the near future.

However, we established that the seclusion room within MAH was accommodated in the PICU. As the PICU remains closed to its previous function the environments currently used for seclusion do not meet required standards. To manage some challenging behaviours in line with best practice the hospital requires access to an operational seclusion room when necessary for patient safety. The Trust should complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance. An area for improvement was made in this regard.

6.3.3 Repurposing of PICU as low stimulus area

The Psychiatric Intensive Care Unit (PICU) temporarily closed on 21 December 2018 and has remained closed since that date in relation to its original function. We found that the Trust had repurposed the PICU as a low stimulus area for patients. We found that patients were being escorted from their wards by staff to the PICU for time limited periods to enable the provision of a low stimulus environment and the de-escalation of challenging behaviours.

We met with a patient experiencing low stimulus in the PICU and with the staff member supporting the patient. We were concerned that as the low stimulus area is some distance from the wards, the ratio of one patient to one staff member could become a safety issue and there could be potential patient safety and comfort issues when transferring patients to this area. If the previous PICU is to be used as a Low Stimulus Area a Statement of Purpose is needed to clearly show how and when the area would be used, taking into account all of the concerns that we raised. An area for improvement was made in relation to the repurposing of PICU as a low stimulus area for patients.

6.3.4 Patient Observations

We reviewed the systems in place for assessing and managing patient observations practices within MAH and found it to be effective. We were informed that the reasons for patients requiring enhanced observations is discussed and agreed by the MDT. We discussed if this was considered to be the least restrictive option and if this was proportionate to the presenting and current risks. We were informed that enhanced observations were reviewed every day by nursing staff and weekly or earlier if required by the MDT. We found that decisions were clearly made and rationales for enhanced observations being continued, reduced or discontinued were recorded in the patients risk assessment and care plan.

6.3.5 Physical Health Care of Patients

We reviewed how the hospital was identifying and meeting the physical health needs of the patients. We found the staff rotas evidenced there was an appropriate number of professionally qualified staff and good availability of the MDT to ensure that the entire range of patients physical health care needs could be met. This included patients accessing gender and age specific physical health screening programmes.

We were informed that the hospital had employed a locum GP since September 2019 who was undertaking work to compile every patient's medical history and current physical health needs into one summary document. Specific attention was being been paid to each patient's eligibility for general population screening and to any individual specific monitoring that may be required e.g. antipsychotic monitoring and diabetic retinopathy screening. This was good to note as some patients had been admitted to the hospital for many years and therefore many of these patients were not registered with a community GP and would not receive automatic general population screening reminders. In addition we found that many of the patients in the hospital presented with complex medical histories and an accessible summary of their physical health was beneficial in relation to meeting their assessed care needs.

We found these summaries were comprehensive, accessible and noted that they would be beneficial for medical staff that may be required to review the patient out of hours. We were advised that this work will continue to be completed across all wards on the site and a system was being built to ensure that any changes in staffing would easily identify the ongoing physical health needs (the general population and patient specific screening programmes) of the hospital's patients.

Review of the patient care records confirmed that patients who were prescribed antipsychotic medication were receiving the required monitoring in accordance with the hospital's antipsychotic monitoring policy. We observed from care records that one patient's daily fluid balance was being monitored and we found that this was completed regularly and in good detail.

As previously stated, the PIpA model has been introduced across the hospital and staff across the MAH spoke positively regarding the benefits it provided. This included more contact with the MDT which provided a more robust decision making process and promoted a culture of shared responsibility; which was welcomed by staff. We established that the multi-disciplinary nature of the PIpA model of care was working well and this enabled all staff to deliver effective care and learn collaboratively as a team.

However, we noted that its introduction had also presented some challenges on certain wards in relation to poor documentation about attendees at the PIpA reviews and also in relation to risk and management plans. One ward's documentation gave the impression that daily PIpA meetings were occurring daily, but on speaking with staff they reported that PIpA reviews were only occurring three days per week. Whilst we were not able to identify any direct impact on patient care, evidence of recent patient weights, monthly physical checks and blood sugars being completed or even offered to patients could not easily be found. We found the recording of this information was not standardised across the hospital and was not easily accessible. Staff told us this information is sometimes stored in a patient's daily progress notes which is not satisfactory and does not lend itself well to auditing for trend analysis. We established that other methods of capturing this patient information were included in the patient's nursing assessment on PARIS or on paper charts which were both more appropriate. In addition, we noted from review of care records that on some occasions when health checks are declined by patients, this is not recorded and there is no evidence to demonstrate that staff have returned at a later date to engage further with the patient in an attempt to encourage the patient to have the test completed.

An area for improvement was made in relation to improving and standardising the documentation used for recording monthly physical health checks across the hospital. A further area for improvement was made in relation to documenting when health checks are declined and ensuring that that there is ongoing collaborative engagement of patients to have health checks completed.

6.3.6 Discharge Planning

We reviewed the arrangements in relation to discharge planning for patients. We spoke with staff and reviewed care documentation relating to patients who had completed their care and treatment and were assessed as delayed in awaiting discharge. Staff informed us that they had access to required detailed information regarding each patient in relation to their discharge plan and assessed needs. Staff were aware of the resources and availability of services in the community which enabled them to ensure that appropriate placements for patients were found and then recorded in the patient's discharge care plans.

6.3.7 Hospital Planning

We reviewed the hospital's forward plan and found that all staff who spoke with us told us that the new management team's style was open, transparent and conducive to staff listening to and supporting one another. Staff reported that they felt supported by the current leadership and management structures.

Staff informed us that they were aware that a comprehensive forward plan for MAH was in development and that this would be communicated to staff, once available.

We were informed by the SMT that the aims and objectives for the hospital's PICU were being developed and this will be disseminated to frontline nursing staff so that there is clarity regarding both the current position of the unit and the staff positions. In the meantime PICU remains closed to its previous use but is repurposed as a low stimulus area. The previous area for improvement was met as all staff were aware that PICU was no longer being used in the way it previously would have been and were aware of its current purpose.

6.3.8 Hospital Governance

We assessed the progress made in relation to strengthening the hospital's governance arrangements. We were encouraged by the improvements in the governance arrangements which were in part, due to better sharing of information on a multi-disciplinary level which had greatly improved since the previous inspections. This was evident in the daily and weekly SITREP, live governance meetings, significant event audits (SEA's), MDT meetings and clinical improvement groups. In addition we found that the hospital governance structure was further strengthened by the strong clinical and managerial leadership team currently on site.

We found that the new interim management team confirmed the Trust's commitment to provide support to the staff and patients on the site. Their style of management was found to be open and transparent and was conducive to staff listening to and supporting one another. Staff feedback to us was positive about the current management team, with all staff confirming that they feel supported by the current leadership and new management structures. We acknowledged the speed and ease with which the majority of documentation or information requested by us was supplied to our inspection team.

Front line staff reported to us that communication across the site from senior management had greatly improved. Staff who spoke with us were knowledgeable about the purpose of the various governance committees and meetings to support leadership and understood the need to provide information for them. Staff told us that they felt involved in the daily and weekly SITREP; live governance meetings; significant event audits (SEA); MDT meetings; and clinical improvement groups.

The daily safety huddle (at ward level) was observed to be taking place on each ward. We found staff were knowledgeable about the benefits of the safety huddle and the additional level of communication it provided. Staff told us that the weekly safety pause (hospital level) meetings were scheduled in to the weekly timetable which provided us with assurance that these meetings were valued and embedded into the overall governance framework of the hospital.

We saw evidence that reporting of SEA's had increased and were being used by the MDT as a learning tool. This was further evidence of the strengthening of the governance arrangements in the hospital and the systems being used in a meaningful way to support staff in the delivery of patient care.

We established that the implementation of the Deprivation of Liberty (DoLS) safeguards process had begun. DoLS ensures people who cannot consent to their care arrangements in a hospital setting are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. We found that the hospital had identified and prioritised those patients who were eligible for safeguards to be implemented under the under DoLS and a lead person had been appointed to undertake this task.

We found that quality improvement had been integrated well into the current governance systems. We noted that through a review of their systems and processes the staff and management teams had created space for themselves to have more opportunities for learning and development. We spoke with the Clinical Director, two consultants, two staff grades and a trainee separately and were told about plans to launch an improvement project next month in relation to reducing violence by patients towards both other patients and staff within the site.

We continue to have concerns regarding the regional work to review and refresh the model for learning disability patients in Northern Ireland, including the resources and availability of services in the community. It was acknowledged that whilst regional infrastructure work was ongoing, it's pace and focus was slow and impacted negatively on the flow of patients both into and out of hospital. The region's understanding of the arrangements relating to patients with severe learning disabilities who need admission to hospital remains a concern. Senior management in RQIA confirmed that we would be happy to advise; assist and support the Trust's management team with these ongoing challenges.

We discussed the interim management arrangements implemented by the Trust. We highlighted the need for a planned and staged approach to the withdrawal of the current interim management team and highlighted the potential negative impact this could have across the hospital if it was not effectively managed.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT on 16 December 2019 as part of the inspection process. The timescales for implementation of these improvements commence from the date of this inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action.

It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified in which action is required to ensure compliance with The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to meet the areas for improvement identified. The Trust should confirm that these actions have been completed and return the completed QIP to BSU.Admin@rqia.org.uk for assessment by the inspector by **18 August 2020**.

Quality Improvement Plan	
Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)	
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Third time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust must: 1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH. **Ref**: **6.3.1**
	Response by the Trust detailing the actions taken: 1. A CCTV Working Group has been set up (this includes representation from ward staff, safeguarding staff, management, governance, litigation and staff unions) to review the current use of CCTV within the hospital. The group are finalising letters of explanation and surveys to family, carers, and patient advocates to capture their views on the current and future use of CCTV within the hospital. Letters and surveys have also been prepared for all staff. This process will further inform a further review of the CCTV Policy and feedback is being sought from patients with support from the Speech and Language Therapy Team.

	(a) The most up to date draft policy has been made available to all staff, including the procedures they should follow. A further review of this policy is currently taking place which will also take into consideration the survey feedback from staff, family, carers and patient advocates. (b) There are agreed procedures in place for the monitoring and management of CCTV images, the relevant templates have been updated and improved following feedback from the Contemporaneous CCTV Viewing Team and from staff. A business case was agreed and actioned in relation to replacing some aspects of the CCTV system in order to be able to retain footage. 2. The CCTV policy has been reviewed and updated to include previous addendums into the main body of the policy. This draft will be presented to the CCTV Working Group for comment following results of the survey mentioned in point 1 above. The updated draft policy now includes a broadened use of CCTV to incorporate training and reflection, support for transition teams in understanding patient support needs, etc. The policy will be presented to the Trust's Standards and Guidelines Committee in December 2020.
Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First Time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH. **Ref**: **6.1**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection. On the 1 March 2020 Muckamore Abbey Hospital pharmacist hours were increased from 0.5wte to 0.8wte on a temporary basis until 31 December 2020. This will be reviewed in December 2020 to establish if the increased pharmacy hours is more appropriate for the site or if there is still a requirement for the recruitment of a Pharmacy Technician. 2. The Site Pharmacist has developed and carried out a full site audit to include omitted does of medicine and standards of completion of administration records. The findings from this audit have been

	communicated to Ward Managers. This audit will form part of a medication audit schedule going forward. The management team are working with the ward pharmacist to agree standards for the use of "when required medicines" utilised to manage agitation to enable an appropriate audit to be taken forward to monitor the effectiveness and appropriateness of its use as part of a de-escalation strategy. As part of medication monitoring, the site participated in the Prescribing Observatory for Mental Health (POMH) audit of monitoring of ID patients prescribed an antipsychotic and the results were received in August 2020. The Clinical Director for Intellectual Disability Services and the Trust Senior Pharmacist will co-present these results in October 2020. The results will be reviewed for learning and an action plan developed to progress any recommendations. 3. The Wards on site use the Trust's approved recording sheet for refrigeration monitoring daily checks. The site pharmacist is presently reviewing the last two months records for all wards as part of her medications audit.
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance. **Ref: 6.3.2**
	Response by the Trust detailing the actions taken: A monthly audit takes place reviewing all periods of seclusion and voluntary confinement that have taken place the previous month across all wards. Episodes of seclusion are discussed at PIpa meetings and MDT meetings. Seclusion episodes are detailed at PIpa, Live Governance and a separate MDT meeting is convened if required. Seclusion levels are reported in both the weekly Safety Report and reviewed bi-monthly at the Governance Committee to provide assurance and oversight to the hospital management team and the collective leadership. A Restrictive Practices Working Group had been set up to have oversight of all restrictive practices used within the hospital including the use of seclusion. The group was stood down during the initial months of the pandemic but will recommence in October 2020 as part of the site's recovery and rebuild plan. The Group will be led by the new Co-Director for Learning Disability services. The Restrictive Practice Working Group will agree a format and timescale of a review of how seclusion is provided on site including environmental assessment taking into account the safety of both patients and staff.

	This review will include a scoping exercise of best practice guidance and ensure that the dignity of our patients is at the centre of any decisions.
Area for Improvement 4 **Ref: Standard 5.3.1** **Stated: First Time** **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff. **Ref: 6.3.3**
	Response by the Trust detailing the actions taken: The Restrictive Practice Working Group will develop a statement of purpose for the use of PICU as a "Low Stimulus Area" – during this exercise the group will take account of the required standards and best practice guidance and ensure the safety of patient and staff.
Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. A lookback exercise has taken place to gather all physical information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. All patient physical health information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe.
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient. **Ref: 6.3.5**
	Response by the Trust detailing the actions taken: When patients decline physical health checks this is documented as "R" in red on the Visual Control Board (VCB) at PIPA with regular revisits (under bloods). If a patient refuses to have bloods done each incident is recorded on a form within the Physical Health Check folder, which tracks the number of times the patient has declined.

	The urgency of bloods / procedures is assessed (usually low), discussions are recorded on the patient notes and PARIS. The MDT consider various strategies with advice from Behaviour Therapists / psychology as to how to encourage this to happen. Ward staff use Social Stories to help patients understand the reason why the procedure is needed and how it happens. This also applies to dental procedures.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	25.09.20
Name of person approving the QIP	Gillian Traub		
Signature of person approving the QIP	Gillian Traub	**Date approved**	25.09.20
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	29 September 2020

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Assurance, Challenge and Improvement in Health and Social Care

Announced Enforcement Inspection Report
02 – 16 April 2020

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

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Membership of the inspection team

Lynn Long	Acting Deputy Director Improvement Regulation and Quality Improvement Authority
Wendy McGregor	Senior Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Carmel Treacy	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Joseph McRandle	Inspector, Finance Team, Regulation and Quality Improvement Authority

Abbreviations

BHSCT	Belfast Health and Social Care Trust
BSO	Business Services Organisation
DAPO	Designated Adult Protection Officer
IN	Improvement Notice
IO	Investigating Officer
MAH	Muckamore Abbey Hospital
MHO	Mental Health (Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of the hospital

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT). The Psychiatric Intensive Care Unit (PICU) had temporarily closed on 21 December 2018 and has remained closed since.

At the time of the inspection there were five wards operational on the MAH site:

- Cranfield One (Male assessment);
- Cranfield Two (Male treatment);
- Ardmore (Female assessment and treatment);
- Six Mile (Forensic Male assessment and treatment); and
- Erne (Long stay/re-settlement).

3.0 Service details

Responsible person: Ms Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Bernie Owens, Director, Neurosciences, Radiology and Muckamore Abbey Hospital, BHSCT.	

4.0 Inspection summary

We undertook an announced remote inspection of Muckamore Abbey Hospital (MAH) from 2 to 16 April 2020 to assess compliance with the outstanding action points contained within the extended Improvement Notice (IN) - IN000004E which related to the governance of patients finances and Improvement Notice - IN000005E which related to adult safeguarding. We did not visit MAH as part of this inspection due to the current impact on all services as a result of COVID-19. We determined that the information we required to confirm compliance could be provided to us electronically and reviewed remotely.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

On 16 August 2019 RQIA issued three Improvement Notices (INs) to MAH in respect to a failure to comply with minimum standards.

- IN000003 - staffing
- IN000004 - financial governance ; and
- IN000005 - adult safeguarding

During our unannounced inspection on 10, 11 & 12 December 2019 we found sufficient evidence to validate full compliance with Improvement Notice - IN000003 relating to staffing. However, while we found evidence of improvement and acknowledge that progress had been

made to address the required actions within the other two Improvement Notices, IN000004 relating to financial governance and IN000005 relating to adult safeguarding we did not find sufficient evidence to validate full compliance with these two Improvement Notices.

We were able to validate compliance with action points 1, 2, 3 (a), 3 (b) and 3 (c) contained within IN000004 and with action points 1 (a), 1 (b), 1 (c),1 (d) and 2 contained within IN000005. While significant progress had been made, we were unable to evidence that action point 3 (d) of IN000004 and action point 3 of IN000005 were fully addressed.

RQIA senior management held a meeting on 13 December 2019 and a decision was made that the date of compliance for Improvement Notices IN000004 and IN00005 should be extended. Compliance with the extended Improvement Notices must therefore be achieved by 19 March 2020. The extended Improvement Notices – IN000004E and IN000005E were issued on 19 December 2019.

This inspection sought to assess the level of compliance achieved in relation to the following outstanding action points:

- IN000004E – that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital
- IN000005E – implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital

4.1 Inspection outcome

Total number of areas for improvement	6*

**Six areas for improvement generated as a result of the inspection undertaken on the 10, 11 and 12 December 2019 were not reviewed as part of this compliance inspection and will be carried forward to the next inspection. No new areas for improvement were identified during this inspection.

As a result of the findings of this inspection we determined the Trust had achieved compliance with the outstanding action points contained within the extended Improvement Notices - IN000004E and IN000005E.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

Prior to the inspection, we reviewed a range of information relevant to the establishment including the following records:

- written and verbal communication received since the previous inspection;
- notifiable events received since the previous inspection;
- the previous inspection report;
- the QIP from the previous inspection; and
- The extended Improvement Notices - IN000004E and IN000005E.

During our remote inspection we requested the following records from the Interim Co-Director for Intellectual Disability:

- findings of the financial audit carried out by BSO;
- records of adult safeguarding and DATIX training provided for Designated Adult Protection Officers (DAPOs), Investigating Officers (IOs), line managers and medical staff;
- minutes of the monthly adult safeguarding forum (January and February 2020);
- evidence of outcomes from analysis of adult safeguarding data;
- minutes of Clinical Governance Meetings (January and February 2020);
- evidence of governance arrangements in place for staff on supervision plans moving around wards;
- outcomes from audits of patient protection plans, all adult safeguarding referrals for January and February 2020 and evidence of compliance with the adult safeguarding referral process; and
- evidence of the development of a communication strategy with carers.

We examined the following areas:

- arrangements for financial governance;
- results of the financial audit completed in February 2020; and
- oversight and management of adult safeguarding arrangements.

The findings of the inspection were provided to the Senior Management Team (SMT) and to Ms Cathy Jack, Chief Executive, BHSCT at the conclusion of the inspection by letter.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection dated 10, 11 and 12 December 2019

As previously outlined in section 4.0 this inspection focused on evidencing compliance with the outstanding action points in IN000004E and IN000005E. Six areas for improvement from the last inspection on 10, 11 and 12 December 2019 were not reviewed as part of this inspection

and are carried forward to the next inspection. The QIP in section 7.2 reflects the carried forward areas for improvement.

6.2 Inspection findings

Improvement Notice Ref: IN000004E

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply:

4.3 Criteria

The organisation:

(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;
(g) has systems in place to ensure compliance with relevant legislative requirements;
(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;
(i) undertakes systematic risk assessment and risk management of all areas of its work.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Improvement necessary to achieve compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must ensure:

- that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

On 2 April 2020 the Trust's (SMT) provided an update to RQIA on the progress made to address compliance with the outstanding action points included in the Improvement Notices via a remote inspection. They informed us that a full audit of the arrangements for financial controls relating to patients had been completed by internal auditors from the Business Service Organisation (BSO) and that a 'satisfactory' rating had been achieved. They told us that there were no Priority 1 findings. The audit identified some Priority 2 findings with associated recommendations. We discussed the findings of the financial audit in detail with the SMT and they provided us with the actions they had taken or where taking to address the recommendations made by Internal Audit.

The Trust advised that BSO Internal Audit had confirmed to them that documentation was in place from the Social Security Agency (SSA) authorising the Trust to act as the appointee for certain patients and that the correct benefits were being received on behalf of those patients. The Trust also advised that Internal Audit had highlighted some minor issues that had arisen from the financial audit which they were addressing.

The SMT told us that Internal Audit had acknowledged that the Trust had sought approval from RQIA to hold balances of patients' monies and valuables in excess of £20,000 in line with article 116 of the MHO.

As the Trust received a satisfactory grade from BSO Internal Audit, we were advised that a mid and end of year assurance report will be required to be submitted by the Trust to Internal Audit. We were told that Internal Audit will review the recommendations from all the Trust reports at a point in time and provide an update in terms of implementation i.e. fully implemented, partially implemented or not implemented for the Trust's Audit Committee in October 2020.

It was good to note that many of the findings in the Internal Audit report concur with RQIA's findings from the unannounced inspection on 10, 11 and 12 December 2019.

We were informed that the SMT within MAH will take the lead in liaising with the Trust's Finance Directorate in order for the Finance Directorate to have the overarching accountability of the financial arrangements for patients within MAH**.** SMT told us they believed links with the Finance Directorate had been greatly strengthened because of the financial audit and that the Patient Finance Liaison Officer based in MAH was a key role in maintaining improvements. SMT advised that they were planning to permanently appoint a Patient Finance Liaison Officer.

On 9 April 2020 the final copy of the audit report was shared with RQIA and reviewed by our inspection team. This verified the information previously provided to us by on 2 April 2020.

<u>Outcome</u>

We found sufficient evidence to determine that this action point had been addressed.

Improvement Notice Ref: IN000005E

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to comply:

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;
(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

Improvement necessary to achieve compliance:

The Belfast Health and Social Care Trust Board, Chief Executive and Executive Team must:

- Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.

During the teleconference on 2 April 2020, the MAH SMT provided a presentation to us outlining how they had embedded into practice the safeguarding improvements we observed during our unannounced inspection of MAH on 10, 12 and 12 December 2019. They described to us the senior management oversight arrangements for the management of safeguarding within the hospital. They shared with us the flow chart displayed on each ward which showed the process for escalating a safeguarding incident and which highlighted the various staff roles in the process.

The SMT told us about good practice improvements which have been implemented which included a comprehensive review of policies and procedures including the seclusion policy, the observation policy and the admission policy. They told us that patients are engaged in more meaningful activity on and off the hospital site in the evenings and at weekends. They also informed us that CCTV is now live across the site and learning from the Adult Safeguarding (ASG) team's viewing of the CCTV is shared at ward manager meetings and at the ASG Forum.

The Purposeful Inpatient Admission (PIpA) model, which provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment, had been further developed and embedded within the hospital. We were

informed that a link person for contact with the Police Service Northern Ireland (PSNI) had now been established and a Service Manager with ASG responsibilities has been recruited.

The SMT told us that action had been taken by the hospital social work team to raise safeguarding awareness among patients through the Keeping Yourself Safe Programme. The programme informs patients about what safeguarding is and what actions they could take if they had a safeguarding concern. We were advised that this will be an ongoing programme for patients.

We were advised that since January 2018, the Keeping Yourself Safe programme had been delivered to 45 patients in MAH and another 33 patients were either offered the programme and declined or had insufficient capacity to participate or have now been discharged from the hospital.

It was established that the programme was not able to sufficiently meet the needs of 22 patients who experienced significant communication difficulties without specialist input and training from the Association for Real Change (ARC) to enable them to participate. The social workers on site have now all been trained in Talking Mats to assist in more effective communication with patients.

We were told that ARC will complete a baseline report of the views of all patients in relation to how safe they feel in the hospital. This will be reviewed every six months. ARC will also complete a post safeguarding investigation questionnaire for any patient involved in a safeguarding investigation. Preparatory work has been completed for both pieces of work to commence as a pilot in one ward.

The SMT informed us that the safeguarding team are now completing pre and post safeguarding investigation questionnaires with carers/relatives and the learning outcomes will be disseminated via clinical governance meetings, safety briefs and the ASG Forum as appropriate. These questionnaires were analysed by the DAPO and will be used to inform future practice. From this analysis, the need for clearer communication with families following a safeguarding incident/referral had been identified and work was underway to develop a communication strategy to engage more effectively with carers.

We were told that the SMT had increased audit activity to embed safeguarding practices within the hospital. Auditing is being used to ensure compliance with and adherence to safeguarding recording standards by both ward staff and safeguarding staff. We were given examples of how these audits had informed improvements in the service provided and patient experience. The current audits shared with us showed good compliance with safeguarding recording standards. Auditing of the contemporaneous viewing of CCTV was ongoing on a weekly basis (each ward was monitored for a 4 hour shift per week) and a viewing sheet was retained. Examples of good practice and areas for improvement were highlighted by the viewing team and addressed through ward managers meetings and by the assistant service managers. We were advised that the contents of the CCTV viewing sheets form part of the hospital's safety report. We noted that one safeguarding incident was identified from the contemporaneous viewing of CCTV footage and appropriate action had been taken.

During our inspection on 10, 11 and 12 December 2019 we evidenced good staff knowledge and awareness of what constitutes a safeguarding referral and the process on how to make a referral. The SMT informed us that in order to be assured of the continued good level of safeguarding knowledge and awareness, audits were conducted within the hospital to test staff

(twenty eight staff in total) about their knowledge of the new safeguarding processes implemented; escalation plans; protection planning; how to refer in and out of hours to ASG; staff responsibilities; how safeguarding information is communicated; and the contact details of the safeguarding team. The result of the audit demonstrated that among all grades of staff knowledge was found to be good.

SMT told us that there is now monthly auditing of ward managers' decision making to screen out safeguarding referrals. This audit showed that no safeguarding referrals had been inappropriately screened out. The SMT informed us about a further monthly audit completed to ensure there was MDT input into protection planning. This audit identified a significant improvement in MDT input into protection planning and risk assessment from October 2019 (52% compliance) to January 2020 (100% compliance).

From the information reviewed and discussed on 2 April 2020, we found that the Trust had made good progress in embedding good practice in respect of adult safeguarding across the hospital. In order to support our decision making about compliance with the outstanding action within IN00005E we asked the Trust to provide the following evidence:

- records of adult safeguarding and DATIX training provided for DAPOs, IOs, line managers and medical staff since our last inspection in December 2019;
- minutes of the monthly adult safeguarding forum (January and February 2020);
- evidence of learning outcomes from the analysis of adult safeguarding data;
- minutes of Clinical Governance Meetings (January and February 2020);
- evidence of governance arrangements in place for staff on supervision plans moving around wards;
- outcomes from audits of patient protection plans;
- all adult safeguarding referrals for January and February 2020 and evidence of compliance with adult safeguarding referral process; evidence of the development of a communication strategy with carers.

The information requested was provided to us on 10 April 2020 and we found that this verified the discussions we had with the SMT on 2 April 2020. Review of the information showed an improvement in training compliance; live discussions around the need for ongoing safeguarding training; staff positivity in relation to the benefits of sharing learning via the ASG forum; and the impact of the improvements on care practices and restrictive practices.

We reviewed evidence of the governance arrangements in place for staff on ASG supervision plans who were moving around wards. This was clearly stated in the escalation policy and we were informed this had been tested by SMT to assure compliance. We were assured that appropriate measures were in place to ensure the safety of patients when staff members on ASG supervision plans are asked to provide relief on another ward.

We were able to verify that the information regarding the outcomes from audits accurately reflected what the SMT told us during the remote inspection and that the results from auditing in relation to patient protection plans led to an improvement in the compliance rating for the next audit. Evidence that improvements were being embedded was also seen in relation to how and where information was stored on the PARIS information system, templates being updated and how and with whom information was shared.

We were assured that steps were being taken to address the concerns raised by carers in relation to safeguarding. We reviewed a draft 10 point communication plan for families and found that a communication strategy was being developed in consultation with the Carer's Consultant to ensure a consistent approach when engaging with carers.

Outcome

We found sufficient evidence to determine that this action point had been addressed.

6.3 Conclusion

We found sufficient evidence was available to validate compliance with the outstanding action points in the extended Improvement Notices IN000004E and IN000005E.

7.0 Quality improvement plan

There were no new areas for improvement identified during this inspection. The attached QIP contains the areas for improvement carried forward from the last inspection on 10, 11 and 12 December 2019. The six areas for improvement will be reviewed at a subsequent inspection.

The Trust should note that if the action outlined in the QIP is not taken to comply with areas for improvement this may lead to further enforcement action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

No new areas for improvement were identified during this inspection. The attached QIP includes six areas for improvement identified during the last inspection on 10, 11 and 12 December 2019.

7.2 Actions to be taken by the service

The Trust is not required to return a completed QIP for assessment by the inspector as part of this inspection process. The QIP reflects the carried forward areas for improvement from the inspection on 10, 11 and 12 December 2019.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPSNI Quality Standards for Health and Social Care (March 2006)	
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Third time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust must: 1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
Area for improvement 2 **Ref**: Standard 5.1 Criteria 5.3.1 (f) **Stated:** First Time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.
Area for Improvement 3 **Ref**: Standard 5.3.1 **Stated:** First Time	The Belfast Health and Social Care Trust shall complete a review of the necessity for a functioning seclusion room taking into account the needs of the patients accommodated in the hospital, safety of patients and staff and the required standards and best practice guidance.

To be completed by: 1 October 2020	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
Area for Improvement 4 **Ref:** Standard 5.3.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a "Low Stimulus Area" taking account of the required standards and best practice guidance and ensuring the safety of patients and staff. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward for review at the next inspection.**

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Assurance, Challenge and Improvement in Health and Social Care

Unannounced Inspection Report
27 and 28 October 2020

Belfast Health & Social Care Trust

Type of Service: Mental Health and Learning Disability Hospital
Muckamore Abbey Hospital
1 Abbey Road
Antrim
BT41 4SH
Tel No: 028 9446 3333

Membership of the inspection team

David McCann	Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Wendy McGregor	Acting Assistant Director, Improvement Directorate, Regulation and Quality Improvement Authority
Carmel Treacy	Lead Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Cairn Magill	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Maire-Therese Ross	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Jillian Campbell	Inspector, Hospital Programme Team, Regulation and Quality Improvement Authority
Joseph McRandle	Finance Inspector, Regulation and Quality Improvement Authority
Gerry Lynch	Medical Peer Reviewer, Regulation and Quality Improvement Authority
Paula Weir	Inspection Coordinator, Regulation and Quality Improvement Authority

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (the Trust). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986 (MHO).

MAH provides a service to people with a Learning Disability from the Trust, the Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT) areas. The Psychiatric Intensive Care Unit (PICU) closed on 21 December 2018 and has remained closed to that purpose since. It has now being used as a low stimulus area and the hospital's seclusion room.

At the time of the inspection, there were five wards operational on the MAH site:

- Cranfield One (male assessment);
- Cranfield Two (male treatment);
- Ardmore (female assessment and treatment);
- Six Mile (forensic male assessment and treatment); and
- Erne (long stay/re-settlement).

On the day of the inspection, there were 50 beds operational in the hospital, 45 patients who were accommodated in the hospital; three patients who were on trial resettlement leave; and two patients who were on extended home leave.

3.0 Service details

Responsible person: Dr Cathy Jack Belfast Health and Social Care Trust	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 50
Person in charge at the time of inspection: Tracy Kennedy, Co-Director Learning Disability	

4.0 Inspection summary

An unannounced inspection was undertaken to all five wards located in MAH which commenced with an onsite inspection from 27-28 October 2020. The inspection was completed on 10 December 2020 following family and advocate engagement. Feedback from the inspection was delivered to the Trust's senior management team on 11 December 2020.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Mental Health (Northern Ireland) Order 1986 and the DHSSPSNI Quality Standards for Health and Social Care (March 2006).

During August 2019 we served three improvement notices to the Trust in relation to adult safeguarding arrangements, staffing and the governance of patients' finances. Compliance with the improvement notice for staffing was determined in December 2019 and in April 2020 for adult safeguarding arrangements and the governance of patients' finances. The focus of this inspection included our determination whether the improvements made by the Trust since April 2020 had been maintained and embedded in practice at the hospital. In addition the areas for improvement identified in the previous Quality Improvement Plan (QIP) from December 2019, were examined during this inspection.

We were pleased to see good practice in relation to:

- the hospital's ethos of using the least amount of restrictive practices to manage patients' behaviours that challenge;
- the management and monitoring of patient's physical healthcare needs;
- the oversight of medicines management within the hospital; and
- the updated operational policy reflecting the varied use of close circuit television (CCTV) within the hospital.

We were concerned that:

- communication of information relayed to families by the adult safeguarding team was not clearly shared with ward staff;
- some families were not content with the level of communication from the ward/hospital/adult safeguarding team about their relative;
- staff were unsure about the actions to take if the ward's medicine refrigerator was found to be outside of the safe temperature range; and
- some patients had not received an audit of their finances by a senior manager.

4.1 Inspection outcome

Total number of areas for improvement	4

There were four new areas for improvement arising from this inspection. These are detailed in the QIP.

Details of the QIP were discussed with the senior management team (SMT) at an online feedback session on 11 December 2020, as part of the inspection process. The timescales for implementation of these improvements commence from that date. Findings of our inspection are outlined in the main body of the report.

This inspection did not result in enforcement action.

5.0 How we inspect

Prior to this inspection, a range of information relevant to the service was reviewed, including the following records:

- previous inspection reports;
- review of the previous returned QIP;
- Serious Adverse Incident (SAI) notifications;
- information about complaints; and
- other relevant intelligence received by RQIA.

Each ward was assessed using an inspection framework. The methodology underpinning this inspection included discussion with patients, staff, relatives, observation of practice, and review of relevant documentation. Records examined during the inspection included nursing care records; medical records; senior management and governance reports; minutes of meetings; duty rotas; and training records.

Areas for improvement identified during previous inspections were reviewed and an assessment of achievement was recorded as met, partially met or not met.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection from 02-16 April 2020

The announced inspection from 02 -16 April 2020 was undertaken remotely to assess compliance with two extended Improvement Notices relating to the governance of patients' finances and adult safeguarding arrangements. Full compliance with the extended Improvement Notices was achieved in April 2020. The QIP generated from the unannounced inspection from 10-12 December 2019 was not reviewed during the April 2020 inspection and was reviewed during this inspection.

6.2 Review of areas for improvement from the previous inspection from 10-12 December 2019

Areas for improvement from the previous inspection		Validation of compliance
Area for improvement 1 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Third time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust must: 1. implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 6.3.1.	

<table>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 5.1
Criteria 5.3.1 (f)

Stated: First Time

To be completed by:
28 August 2019</td><td>The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas:
1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time.
2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy.
3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met. Further detail is provided in section 6.3.2.</td></tr>
<tr><td rowspan="2">Area for Improvement 3

Ref: Standard 5.3.1

Stated: First Time

To be completed by:
1 October 2020</td><td>The Belfast Health and Social Care Trust shall complete a review of how seclusion is provided on the site taking into account the safety of both patients and staff. The Trust should also take into account the dignity of patients and best practice guidance.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met. Further detail is provided in section 6.3.3.</td></tr>
<tr><td rowspan="2">Area for Improvement 4

Ref: Standard 5.3.1

Stated: First Time

To be completed by:
1 October 2020</td><td>The Belfast Health and Social Care Trust shall outline a statement of purpose for the use of the PICU as a “Low Stimulus Area” taking account of the required standards and best practice guidance and ensuring the safety of patients and staff.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This area for improvement has been assessed as met. Further detail is provided in section 6.3.4.</td></tr>
</table>

Area for Improvement 5 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall develop and implement a systematic approach to the documentation used throughout the hospital for the recording of patients' physical health checks. **Action taken as confirmed during the inspection**: This area for improvement has been assessed as met. Further detail is provided in section 6.3.5.	**Met**
Area for Improvement 6 **Ref**: Standards 5.3 and 7.1 **Stated:** First Time **To be completed by:** 1 October 2020	The Belfast Health and Social Care Trust shall ensure if physical health checks are declined by the patient, this must be recorded in the patient's care records and evidence retained of ongoing attempts to engage the patient. **Action taken as confirmed during the inspection**: This area for improvement has been assessed as met. Further detail is provided in section 6.3.6.	**Met**

6.3 Inspection findings

6.3.1 Close circuit television (CCTV)

We reviewed the arrangements in relation to the oversight and governance for the use of CCTV within the hospital. We found that there was an effective process in place for contemporaneous monitoring and management of CCTV images. We were provided with records of contemporaneous CCTV viewing from 09 March to 20 October 2020. We found that CCTV viewing occurs, at various times over the 24 hour period of each day, 7 days a week, and across different wards including day care.

We reviewed the minutes of three live governance meetings (01- 15 October 2020) and found that the CCTV viewer's findings were discussed. The CCTV viewer's records evidenced where good practice was highlighted and where poor practice or incidents, which met the criteria for an adult safeguarding referral, demonstrated appropriate action was taken.

We reviewed patients' care records and adult safeguarding multidisciplinary team (MDT) protection plans. We saw evidence that CCTV images were used to assist in decision making if there was uncertainty about staff's use of Management of Actual or Potential Aggression (MAPA) restraints and in relation to making referrals to adult safeguarding.

We were informed that Assistant Service Managers (ASMs) and Designated Adult Protection Officers (DAPOs) were provided with CCTV viewing records every week to review and triangulate information relating to their wards. We found evidence that this was an effective process and found that adult safeguarding or practice issues were dealt with in a timely manner.

We reviewed the draft CCTV policy. The policy incorporated new areas relating to staff training and reflection and increasing the understanding of patient support needs. The SMT informed us that a CCTV working group had been set up to review the current use of CCTV within the hospital which included representation from staff of varying grades and disciplines, litigation services and trade unions. The group were finalising a survey seeking the views of patients, family, carers, patient advocates and staff on the current and future use of CCTV within the hospital. We were informed that Speech and Language therapists were supporting patients to provide their feedback to the working group about the use of CCTV. We were advised that the feedback obtained from the survey would further inform the final draft of the CCTV Policy.

Whilst the current CCTV policy remains in draft form, it has been made available to all staff pending further review when feedback from all relevant parties is considered. It is planned that the final draft of the policy will be presented to the Trust's Standards and Guidelines Committee in December 2020 for approval. We determined that this addresses the previous area for improvement outlined in section 6.2.

6.3.2 Medicines management

We reviewed how the Trust had strengthened arrangements for the management of medicines since the previous inspection. We found that the hospital's pharmacist hours had been increased from a 0.5 whole time equivalent (wte) to a 0.8 wte on 01 March 2020, for a temporary period until 31 December 2020. We were informed that plans were in place to review the increase of the pharmacy service in December 2020 and a decision will be made to either recruit a pharmacy technician or permanently increase the pharmacist's hours.

We spoke with staff on the wards and they were very positive about the pharmacist's input. They told us that the pharmacist attends the Purposeful Inpatient Admission (PIpA) meetings regularly and provides their specialist knowledge, which is welcomed. The PIpA model introduced by the Trust provides an increased multidisciplinary review of each patient and involves shared decision making around care and treatment issues and risk assessment. We reviewed audits that had been undertaken in relation to omitted doses of medicines; standards of completion of administration records; and the effectiveness and appropriateness of the administration of "when required" medicines, that are utilised to manage agitation as part of a de-escalation strategy. The SMT informed us that their plans to implement an audit schedule to provide the ongoing assurance of the high standards we observed was delayed due to the impact of the Covid-19 pandemic, however, they expected this audit schedule to become operational soon.

Ward staff informed us that the pharmacist provides a level of scrutiny over missed doses of medications and advice regarding drug interactions and cross titration of antipsychotic medications. The pharmacist also calculates the combined antipsychotic medication daily dose for individual patients to ensure this falls within safe limits. Staff told us that the pharmacist's input during the Covid-19 pandemic surge period regarding intravenous fluids and oxygen was invaluable. They also reported that the increase in the pharmacy service within the hospital has made the process of prescriptions for patients going on leave from the hospital much more refined, thereby reducing delays.

We reviewed a sample of 20 medicine kardexes and found a good standard of prescribing. We noted that recording of medicine administration was well completed and the patients' allergy status was documented on all kardexes reviewed. Antibiotic prescriptions included indications for use and treatment lengths were documented.

There was a minimal amount of multiple antipsychotic prescribing and a clear rationale was described by the Consultant in these cases. We found evidence that as and when required (PRN) medication was prescribed in the context of any regular prescriptions of the same medication. PRN medication usage was discussed daily at PIpA meetings and weekly live governance meetings for trend analysis. We found that PRN medication usage was proportionate, judicious, and fell within maximum dose limits which indicated that PRN medications were not used as a form of restrictive practice.

We reviewed the daily records for medicine refrigerator temperature monitoring to ensure these accurately reflected the actual, minimum, and maximum refrigerator temperatures. We found evidence that these checks were being completed daily and that records were being kept on all wards. We determined that the previous area for improvement outlined in section 6.2 had been met.

We spoke with staff about the actions to take on occasions when the medicine refrigerator temperature fell outside of the required temperature and found there was a lack of clarity about the correct actions to take. We established there was no advice available for staff to guide them on the appropriate steps to take to ensure the integrity of the medications contained in the refrigerator. An area for improvement is stated to ensure that an escalation procedure for managing temperature variances in medicine refrigerators is developed which guides staff to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range.

6.3.3 Review of how seclusion is provided on the site

We reviewed the arrangements in place to provide seclusion on the site. The SMT informed us that a Restrictive Practices Working Group had been established to have oversight of all restrictive practices used within the hospital. The group was stood down during the initial months of the Covid-19 pandemic but had recommenced in October 2020 as part of the site's recovery and rebuild plan.

We saw clear evidence of where seclusion was used; as a last resort; proportionate to the risks presented by the patient and; after all deescalating techniques, as recorded in the patients' positive behaviour support plan, were implemented. These approaches include encouraging patients to avail of low stimulus areas with their agreement, within designated low stimulus areas designed to promote a calm environment for patients who have difficulty in managing their emotions and who require support during times of emotional dysregulation and distress. Patients can avail of therapeutic one to one time with a staff member allowing them to explore their feelings in an area that protects their dignity.

Staff described the use of voluntary confinement. This is the term used to describe requests from patients to be confined to their bedroom and to have the door locked as part of their behavioural support plans. Voluntary confinement, as part of an agreed care and treatment plan, is only in place for specific patients who have used this as an approach to manage their behaviour over a significant period of time. We established that the patients who use this approach to self-manage their behaviour can exit their voluntary confinement at any time of their choosing. We determined that when a patient requests voluntary confinement they are subject to the same level of support and observation levels that a patient would otherwise have, had they been in seclusion. We saw evidence that the decision making and care planning for voluntary confinement involves significant MDT discussion and consultation with family. We saw evidence of a care plan for a patient who uses voluntary confinement which was subject to regular review. We were satisfied that all appropriate safeguards were in place which included consideration for the patients' human rights.

Seclusion occurs when a patient is formally placed in a specifically designated room for the short-term management of disturbed/violent behaviour. We saw evidence of care planning for patients who may require this intervention which had been agreed by the MDT and shared with their family. The care plan and the seclusion policy outlined the strict monitoring and observation procedures to be followed by nursing and medical staff with the aim of ending seclusion at the earliest opportunity. It was good to see that the hospital applied the same monitoring and governance standards to all of these interventions.

All episodes of voluntary confinement/low stimulus/seclusion are discussed at PIpA meetings, MDT, and live governance meetings. A monthly audit is undertaken across all wards taking account of all episodes of voluntary confinement/low stimulus/seclusion use. We saw evidence that this information is reported in the weekly Safety Report reviewed by SMT and are reviewed bi-monthly at the Director's Governance Committee. We were assured by the systems and processes in place and determined that the SMT had good oversight and governance of restrictive practices including the use of voluntary confinement/low stimulus/seclusion within the hospital.

We observed that the site continues to have one operational seclusion room which is located in the former PICU. The PICU closed to its previous function on 21 December 2018. It is now being used as a Low Stimulus Area along with accommodating the seclusion room. The Restrictive Practice Working Group carried out a review of how seclusion was provided on the site and concluded that the current facilities available to patients were appropriate in meeting their needs to required standards.

We reviewed audits and found evidence that the use of low stimulus/voluntary confinement/seclusion on the site had reduced significantly and SMT told us they are committed to an ethos of least restriction. We determined that area for improvement as outlined in section 6.2 had been met.

6.3.4 Statement of Purpose for the "Low Stimulus Area"

A draft Statement of Purpose (SoP) for the Low Stimulus Area was provided by the Trust following the inspection. The draft clearly outlined the rationale for the provision of this area and considered how it would be provided within the former PICU and in Sixmile ward. The Trust planned to consult with staff, patients, their families and other stakeholders to ensure a wide range of feedback on the SoP could be considered. They plan to add to the SoP so that robust guidelines will be developed to direct staff about the required operational procedures to be followed when this area is to be used. We determined that the area for improvement as outlined in section 6.2 had been met.

6.3.5 Standardised documentation of physical health care records

We reviewed the arrangements in place for the management of patients' physical health care needs. We examined a sample of patient care records and evidenced that all patients had a robust medical history completed by a General Practitioner (GP), which included a comprehensive family history. These histories along with antipsychotic medication monitoring checks were located in one folder on each ward which made it easy for all staff to be quickly apprised of any specific patient's physical health care status. All care records reviewed also evidenced that anti-psychotic monitoring was up to date.

Population screening programmes have a key role to play in the early detection of disease and a range of programmes are currently available in Northern Ireland.

The SMT informed us that patients who meet the criteria set out by the Public Health Agency for population screening have had their screening completed and have been added to the registers to ensure they are appropriately called in line with the general population. Population screening programmes include abdominal aortic aneurysm screening and surveillance monitoring; routine breast screening; bowel cancer screening; cervical screening; and routine diabetic eye screening and surveillance monitoring.

We found that patients' physical health care histories were also stored on the PARIS electronic care records system. We found evidence that patients' physical health care was discussed daily at the PIpA meetings and all wards were documenting this information in the same way. We were assured that there were robust systems in place for the oversight and management of patients' physical health care needs and determined that the previous area for improvement as outlined in section 6.2, had been met.

6.3.6 Ongoing engagement of patients who decline physical health care checks

We reviewed how the hospital was identifying and meeting the physical health care needs of the patients and in particular what action was taken when a patient declined physical health care checks. We reviewed a sample of patient care records, ward diaries, and physical health care folders and saw evidence that when patients' decline a physical health care check this is recorded in their care record, the physical health care folder, and the ward diary to alert staff of the ongoing need to encourage the patient to participate in this check. We found an example of good practice and patient centred care in one ward where the ward manager allocated a blood sample to be taken on a specific day as the staff member on duty had a particularly good rapport with the patient. The ward manager had recognised that this professional rapport with the identified staff member could help to put the patient at ease during the procedure and reduce any anxiety or distress.

We were informed that the psychology department works closely with ward staff to help better understand the patient's rationale for declining a physical health care check. There was evidence that the MDT considers various strategies and collaborates with the behaviour therapists to encourage patients to accept necessary physical health care checks. Social Stories were used by ward staff and behaviour therapists to help patients understand the reason a procedure may be required and what the procedure may entail. This also applied to patients requiring dental care and treatment.

We were told that some wards have electronic visual control boards for use during PipA meetings and when patients on these wards decline a physical health care check/procedure it is highlighted in red on the board. The number of times the patient has declined the check is also recorded. We found evidence within the patients' care records that the urgency of requested blood samples or other procedures was assessed and discussed by the MDT. We determined that this addresses the previous area for improvement outlined in section 6.2.

6.3.7 Patients finances

We reviewed the arrangements in place for the management of patients' monies and valuables. We found that, in line with the Trust's policies and procedures, ASMs randomly selected records of monies and valuables held for two patients, per ward, per month. Staff confirmed that as these audits were random the monthly sample could include patients that had already been selected for an audit the previous month. We found that two patients, across all wards, had not been subject to an audit by the ASMs since April 2019.

We asked the Trust to prioritise these patients at the next monthly audit and to ensure that all patients are subject to an ASM audit at least annually. An area for improvement was made relating to the ASM's monthly audit of patients' monies and valuables.

Ward staff were adhering to the Trust's policy of two staff checking patients' ledgers at each handover. Most ward managers were randomly auditing patients' ledgers weekly, in addition to the daily checks.

We were informed by the Patients' Finance Liaison Officer (PFLO) that the ward managers receive patients' monthly transaction reports, which are forwarded from the Trust's cash office. The monthly reports detail the transactions undertaken on behalf of patients during the month and the balance of monies held for each patient at the end of the month. The ASMs include these transaction reports in their monthly audits of patients' monies and valuables. A copy of the monthly audit reports is forwarded to the PFLO who, along with the ASMs, compares them against the previous month's reports, notes any discrepancies/issues and if required, follows up with the service managers. This was found to be in line with the Trust's policies and procedures.

In relation to Patients' Private Property (PPP) accounts we saw evidence that patients' accounts were reconciled, and continue to be reconciled, to the benefits received on behalf of each patient, which the Business Services Organisation (BSO) Internal Audit had confirmed in February 2020.

The PFLO confirmed that SMT reviewed and approved the Policy for Patients' Finances and Private Property, however, the policy had yet to be approved by the Trust's Policy Committee. Discussions with ward staff also confirmed that they were adhering to the procedures for patients' cash within the new policy; however, the checks on patients' property were still performed annually rather than quarterly as per the new policy.

BSO Internal Audit had recommended that the procedure for patients' property to be checked quarterly, in line with the new policy, should be implemented by 31 December 2020. We will review this procedure at the next inspection of MAH.

We were informed by the PFLO that additional training materials for patients' finances and property were recently developed. The layout of the training materials was being finalised and this would be available for ward staff on the Trust's e-learning system in the near future.

Discussions with the PFLO confirmed that financial support plans had been developed for all patients in MAH. We reviewed a sample of the support plans and confirmed that the plans included the details of the current financial arrangements for patients, the financial support provided to patients and the details of the staff member within the Trust authorised to manage the patients' finances. The plans also provided details of the weekly/monthly income received for each patient and a breakdown of the estimated weekly/monthly expenditure for each patient.

Discussions with the PFLO confirmed that the Trust had a contract with an independent advice centre that assisted patients or their representatives with social security benefits. Patients were offered a full review of their benefits to ensure that they receiving the appropriate benefits. We were informed that four patients had not received a review offered by the advice centre. Of the four patients that did not receive a review, three had family members who acted as their appointee and they had declined the offer. The remaining patient's appointee was a member of staff from another Health and Social Care Trust. The BHSCT had contacted the other Trust however it had not received a reply accepting or declining the review.

A review of records evidenced that BSO Internal Audit had confirmed that all patients for whom the Trust manages patients' monies and valuables, in excess of 20k, had received consent from us to hold these monies and valuables for each patient in line with the legislation.

In general, we were satisfied that the processes for managing patients' finances and property had significantly improved from previous inspections in 2019. The practices and documentation developed and implemented by the Trust could be used as a benchmark for good practice by other Trusts managing patients' finances and property.

6.3.8 Staffing

We reviewed the staffing arrangements to ensure that they meet the assessed needs of the current patient population. We were provided with copies of each ward's Telford staffing model. This model considers patient acuity and dependency which in turn determines the level of staffing required to safely care for patients. The model was developed by the SMT, in conjunction with ward managers. The model can be used to respond quickly to temporary or unplanned variations in patients' assessed needs and/or service requirements.

We were informed by the SMT and ward staff that ward staffing levels were reviewed daily and on Fridays, there is a review of the requirements for the weekend. We were informed that there is an out of hours (OOH) Co-Ordinator who can review staffing levels and address any deficits on site during the OOH period. Staff were knowledgeable about the process of escalating staffing issues to the SMT and OOH Co-Coordinator. Staff told us about the on call rota for medical and senior management cover and reported that they felt very supported. Staff understood the need to assist other wards across the site if those wards were short staffed and they demonstrated a willingness to do so. They told us that the improved communication across the hospital helped them to understand the pressures each ward faced daily and we found that staff morale was good.

We reviewed the ward duty rotas and found that staffing levels were appropriate to meet the assessed needs of the patients accommodated and the staff informed us that prescribed patient observation levels could be met. The hospital continues to rely on agency staff to fill staff vacancies. Many of the agency staff had accepted block bookings which provides consistency of care to patients and demonstrates their greater level of commitment to MAH. One former member of agency staff had recently been recruited to a permanent Band 7 post. We determined that significant progress has been made to ensure agency staff were fully integrated into the day to day running of the hospital

We reviewed the induction plans and competency frameworks for staff taking up posts and found evidence of a structured plan which covered the required competencies. Additional competencies required for staff who take charge of the ward are in place. We sought assurances regarding agency staff training and were informed that staff at the hospital site do not have direct access to the agency staff member's training records. The SMT informed us that assurances relating to agency staff's training forms part of the contract the Trust has with the agency and that the responsibility for providing appropriate training lay with the agency. The process for booking agency staff includes the Trusts stipulation of the level of experience and training required, for example, MAPA and adult safeguarding, and the agency subsequently provides suitably qualified staff. However, the SMT did recognise the need to strengthen the governance arrangements with respect to agency staff training records and had begun to seek these assurances with the assistance of the Trust's Nurse Bank.

The SMT indicated that they were willing to offer agency staff access to the Trust's training programmes to make it easier for them to access updates. We were informed that the Trust had provided an adult safeguarding training session for agency staff the previous week.

Ward managers told us when they are planning staffing levels for the ward they take into account the impact of staff who remain subject to supervision plans due to the ongoing investigations into the historic allegations of patient abuse. Since the inspection we have been engaged in work with the Trust, PSNI and the Department of Health seeking ways to strengthen the assurance processes with respect to this cohort of staff.

6.3.9 Adult safeguarding

We examined the management of adult safeguarding arrangements within the hospital. We reviewed eight incidents that had resulted in referrals to adult safeguarding and found evidence that patient protection plans were in place, if required, and were held centrally on the ward. We spoke with staff and found they were knowledgeable about the content of the protection plans. We found evidence that information regarding protection plans and incidents were communicated at every handover, recorded on the daily safety briefs, documented in the patient's care records, and discussed with the MDT at the PIpA meetings.

The staff we spoke with, including agency staff, knew what would constitute a referral to adult safeguarding. They were able to describe the process of how to escalate incidents to the nurse in charge and how to make a referral to adult safeguarding, if necessary.

We were told by the SMT and ward staff that a Nursing Development Lead had conducted an adult safeguarding training session on the site the previous week. Most of the staff were aware of the terms DAPO (Designated Adult Protection Officer) and IO (Investigating Officer) as outlined in the Northern Ireland Adult Safeguarding Partnership: Adult Safeguarding Operational Procedures (2016). The staff that we spoke with knew who the aligned social worker was for the ward and the names of the DAPOs. We could see from a review of the competency framework, which allows agency nurses to take charge of a ward upon successful completion, that knowledge of safeguarding and the ability to make a referral to adult safeguarding was included.

We spoke with ward managers who were aware of the process of escalating allegations of staff abuse of patients to the SMT and of the requirement to inform the Trust's Nurse Bank if the staff member involved was agency staff so that the relevant agency would be notified. Ward managers were knowledgeable about staff whose practice was restricted until the adult safeguarding investigations were completed. They demonstrated good awareness about the requirement to inform other ward managers of the nature of the restrictions if the staff member was asked to provide cover on another ward.

We were informed that there was a weekly adult safeguarding team meeting which provided an opportunity for the team to discuss any new incidents, changes required to protection plans or to plan strategy meetings.

In some incidents we reviewed we were unable to establish if or when the patient's next of kin (NOK) had been notified about the incident. We were informed by ward staff that if an incident occurs during working hours the adult safeguarding team has the responsibility of informing the NOK. We found that there was potential for inconsistent communication of incidents to the NOK. An area for improvement has been stated to develop a clear and robust communication plan providing clarity to all groups of staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the

information and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.

6.3.10 Restrictive practices

We undertook a review of how restrictive practices are managed within the hospital to ensure that it was in line with best practice guidance. We reviewed the minutes of three of the hospital's live governance meetings (01/10/20 – 15/10/20), three of the hospital's weekly Safety Reports (28/09/20 – 08/10/20), three of the monthly Director's Oversight Meetings (June – August 2020), and the Trust Board Meeting for 02 July 2020. We saw evidence that the use of restrictive practices; seclusion; physical interventions; enhanced observations; and the use of PRN medication was discussed and monitored for trend analysis at these meetings.

We reviewed 12 patient care records and found evidence that a restrictive practice care plan was in place for each patient outlining the restrictions that the patient was subject to. In all the records sampled, we saw evidence that the rationale for the restrictive practice was recorded and there was evidence of MDT input during the assessment phase and review of the restrictions.

The 12 patients care records we reviewed had a positive behaviour support (PBS) plan in place which was reviewed regularly at PIpA meetings. These plans offered staff guidance on the most effective ways to provide support to patients who may be using a particular behaviour as a means of communication. These PBS plans were developed using a psychological formulation. In addition to the PBS plans, we found that every patient had a shortened version of that plan (the "grab sheet") which was available for staff to quickly understand the actions they should take to support the patient to de-escalate their behaviour. The "grab sheet" formed part of a pack that could be sent with any patient requiring emergency medical attention at another hospital to quickly inform staff who were unfamiliar with the patient's behaviours and how best to support them to reduce the likelihood of resorting to restrictive practices.

We spoke with ward staff who informed us that the focus of one PIpA meeting per week is to look more closely at restrictive practices. We observed staff supporting patients who were experiencing high levels of distress in a caring and compassionate way. The staff we spoke with demonstrated good knowledge about the range of practices that constituted a restriction and there was evidence of a culture of using the least restriction possible to effectively manage patient's behaviours. Staff told us that they felt supported through the structured debriefing sessions that followed incidents.

We examined audits in relation to the use of low stimulus/voluntary confinement/seclusion episodes and found good compliance with the recording in line with the Trust's policy and procedure, the required standards, and best practice. In one ward, we were provided with evidence of a substantial reduction in seclusion episodes for one patient and we were informed that the patient's quality of life had improved as a result. The patient now leads a more independent life and is able to engage in a wider variety of activities at locations outside of the hospital. We reviewed the care records of a patient who uses voluntary confinement and we were satisfied that this was being treated as seclusion and managed appropriately.

From our review of the restrictive practice audits, we saw evidence that the use of physical interventions had also reduced. We reviewed patient care records and could clearly see an ethos of attempts to de-escalate behaviours and use least restrictive options to support patients. We determined that the Trust had a robust governance and assurance framework regarding the use of restrictive practices.

6.4 Engagement

6.4.1 Patient engagement

We provided questionnaires to patients. Three patient questionnaires were completed, returned to us, and analysed following the inspection. All indicated a good level of satisfaction with the care provided to them in the hospital. However, a patient commented that changes to their personal care team were not communicated with them and another patient commented that the food was poor quality, particularly the meat. We provided this feedback to the SMT to address.

6.4.2 Engagement with relatives/carers

Due to the impact of the Covid-19 pandemic, restrictions to visiting were in place during our on-site inspection and as a result we did not have the opportunity to meet with the relatives/carers of patients. To ensure we captured relative/carer views we wrote inviting them to engage with us to share their opinions about the care and treatment provided to their relative in the hospital.

We received 12 completed returns from the relatives/carers we contacted. Of the 12 responses, 50% of the respondents were entirely satisfied with the care and treatment provided to their relative, 33% returned mixed feedback and 17% were unhappy with most of the care and treatment provided to their relative in the hospital. We raised the specific concerns, highlighted by relatives/carers, with the SMT who sought further information from the relevant ward managers. The SMT provided a timely, robust account of actions that had been taken. We were assured that they had previous knowledge of all of the issues which were highlighted to us and that appropriate actions were undertaken or were being taken to address the relatives'/carers' concerns.

We were informed by one relative/carer about the excellent communication strategy between themselves and the Trust. The result of which meant that their relative was able to access home leave two days every week which was a positive outcome for the patient and their family.

From the feedback we received, we found that whilst some families are very happy about the communication they have with the hospital, others either stated that it has been a long journey to reach the currently acceptable level of communication or that they had ongoing difficulties. One relative stated that all she wanted was a two minute phone call each day, particularly during the Covid-19 pandemic surge and the subsequently restricted visiting, to be updated on how their relative's day had gone. Another relative expressed how it was more beneficial for them to know how the patient's mood was than the more high level information about safeguarding referrals or medical information. A relative/carer also told us that they did not want to feel they were being a burden to staff by contacting the ward.

During our inspection, one of the ward managers was able to provide an example of an individual communication strategy that had been agreed with a patient's relatives. We commended this as good practice.

We determined that a blanket communication policy for all relatives/carers would not address their specific, individual requirements as the information they wanted regarding their relative varied greatly in type and level of detail.

An area for improvement has been stated in relation to developing and implementing a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment. The agreed communication strategy should be documented and accessible to relevant staff.

6.4.3 Staff engagement

During the inspection, we spoke with staff and also invited them to complete an electronic questionnaire, however, no completed staff questionnaires were returned to us.

6.4.4 Advocacy Services

We spoke with the two advocacy service managers who provide the advocacy service to patients in MAH and both reported a positive relationship with all staff on the hospital site and advised that members of the SMT are easily accessible. They told us that advocacy provision is a well-established service and that hospital staff ensure that referrals to the service are made promptly and that patients are facilitated in accessing this service.

We were told that patients are able to access the advocacy service upon admission to the hospital. Patients who are deemed not to have capacity or who have no verbal communication are routinely allocated an advocate. The advocacy service managers confirmed that the advocates are invited to appropriate meetings and feel empowered to challenge staff if required. It was positive to hear that the advocacy arrangements within MAH have been strengthened.

The advocacy service managers informed us that whilst face to face contact had been temporarily suspended, in March 2020, due to the impact of the Covid-19 pandemic advocates could maintain their role, to a degree, by participating in online video call review meetings and were provided with updates from ward staff at least every week for patients who had reduced verbal communication. We were advised that face to face contact has gradually resumed with some good infection prevention controls in place. The advocacy service managers did not have any concerns about the current care and treatment of any patients they are in contact with.

They informed us that most of the advocate's work relates to the resettlement of patients to accommodation outside of the hospital. We were told that the issue causing the most frustration currently for patients, carers, and staff is the slow pace of the resettlement of the patients.

Advocacy staff told us about the compassionate practice of ward staff in involving patients in the resettlement process. This included patients visiting the site of their new accommodation to help them understand the building process as they may be unable to understand it viewing the plans alone. This was commended as good practice.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the SMT, as part of the inspection process, on 11 December 2020. The timescales for implementation of these improvements commence from the date of the inspection feedback.

The Trust should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further action. It is the responsibility of the Trust to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

Areas for improvement have been identified and action is required to ensure compliance with The Mental Health (Northern Ireland) 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">The Trust must ensure the following findings are addressed:</td></tr>
<tr><td colspan="2">Communication between teams</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 5.1
Criteria 5.3.2 (d)

Stated: First Time

To be completed by:
31 March 2021</td><td>The Belfast Health and Social Care Trust shall ensure that a communication plan is developed which provides clarity to all staff about the information provided to the NOK following an incident, the date and by whom the information was provided, the NOK's response to the information, and the follow up arrangements planned. This information should be recorded in a standardised manner across the hospital site.

Ref: 6.3.9</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
An escalation plan is in place outlining whose responsibility it is to notify the next of kin of an incident during working hours and outside working hours following an Adult Safeguarding referral.

To ensure consistency of the information being shared with next of kin by ward staff, the Adult Safeguarding team has developed guidance which has been shared with the Service Manager, Assistant Service Managers and ward staff.

In addition, the Adult Safeguarding team along with the operational management are in the process of agreeing a template, which will be completed and placed in the patient's file and on the electronic PARIS record. This will include the details of what information has been shared with the next of kin following an adult safeguarding incident, by whom, the date of the incident, the date the contact with the next of kin was made, the response of the carer and what follow up arrangements have been in place - by whom and by when.</td></tr>
<tr><td colspan="2">Engagement with relatives/carers</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 6.1
Criteria 6.3.2

Stated: First time

To be completed by:
31 March 2021</td><td>The Belfast Health and Social Care Trust shall develop and implement a communication strategy that will ensure that relatives/carers receive their requested level of communication about their relative's care and treatment in Muckamore Abbey Hospital. The agreed communication strategy should be documented and accessible to relevant staff.

Ref: 6.4.2</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
The Trust has been developing a commitment to carers statement and a communication agreement template. This has been developed in conjunction with staff, a number of carers and advocacy services through the Carers Forum.</td></tr>
</table>

<table>
<tr><td></td><td>This includes details of the next of kin's preferred method of keeping in touch, frequency of contact etc. This information will be recorded in the agreed template which will be kept in each patient's file within the ward and on the electronic PARIS system.

A key contact information sheet containing the contact details of staff involved in each patient's care has also been developed. This will also be recorded in the agreed template which will be kept in each patient's file within the ward and on the PARIS system.

There are plans for this to be rolled out.</td></tr>
<tr><td colspan="2">Escalation procedure for temperature variances in medicine refrigerators</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 5.1
Criteria 5.3.1 (f)

Stated: First time

To be completed by:
31 March 2021</td><td>The Belfast Health and Social Care Trust shall ensure that an escalation procedure for temperature variances in medicine refrigerators is developed to guide staff in Muckamore Abbey Hospital to take the appropriate actions if medicine refrigerators fall outside the permitted temperature range.

Ref: 6.3.2</td></tr>
<tr><td>Response by the Trust detailing the actions taken:
An escalation procedure has been agreed and a flowchart developed to provide guidance to staff to ensure they are aware of what action is required when temperature variances occur in medicine refrigerators. The flowchart has been laminated and attached to each refrigerator. The flowchart is accessible to all staff and staff will be taken through the procedure as part of medication training.</td></tr>
<tr><td colspan="2">Monthly audit of patients' monies and valuables</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 4.1 & 5.1
Criteria 4.3 & 5.3 (5.3.1)

Stated: First time

To be completed by:
31 March 2021</td><td>The Belfast Health and Social Care Trust shall ensure that all patients in Muckamore Abbey Hospital are subject to the Assistant Service Manager's monthly audit of monies and valuables at least annually.

Ref: 6.3.7</td></tr>
<tr><td>Response by the Trust detailing the actions taken:

A process has been implemented to ensure that a different patient's records each month forms part of the financial audit. A schedule has been developed per ward listing each patient and recording the date of when their financial records were last audited and the date they will audited next. This process will ensure that each patient's financial records including monies and valuables are audited at least annually.</td></tr>
</table>

Please ensure this document is completed in full and returned via Web Portal

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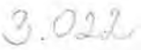
Assurance, Challenge and Improvement in Health and Social Care



Minutes of the Trust Board Meeting
Held on 05 September 2019 at 11.00 am
in the Boardroom, Belfast City Hospital

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director of Finance

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Ms Charlene Stoops	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mrs Orla Barron	Equality Lead and Corporate Planning
Dr Margaret Flynn	Chair, SAI Panel, Muckamore Abbey Hospital

Apologies

Dr Patrick Loughran	Non-Executive Director
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development

Mr McNaney welcomed everyone to the meeting, particularly Mr Aidan Hanna and Mr Pat McDonald, NI Patient Voices, who had requested and been, granted Speaking Rights in respect of Muckamore Abbey Hospital.

Services User Story – Adoption Services

Presentation deferred and will be rescheduled.

27/19 Minutes of Previous Meeting

The minutes of the previous meeting held on 5 September 2019 were considered and approved.

28/19 Matters Arising

No items raised.

29/19 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

b. Chairman's Awards Visits

Mr McNaney referred to the programme of Chairman's Awards Visits, being undertaken by Mrs McKeagney, and Professor Bradley and himself and extended an invitation to all Non Executives to join them if available. He commended the visits as an excellent opportunity to meet frontline staff.

c. BBC Documentary "Hospital from the Inside"

Mr McNaney referred to the recently televised "Hospital from the Inside" programmes, which featured the Royal Victoria and Belfast City Hospitals and followed patients through surgery and treatment. The programmes had featured highly skilled and dedicated staff, and showed how committed teams react when services are under pressure. Filmed over the winter of 2018/19, the documentary was an open and honest account of the challenges facing the health service. It also explored the life changing and lifesaving work staff carry out on a daily basis.

Mr. McNaney expressed pride in the inspirational staff who had demonstrated their commitment and dedication to patient care; he asked that Trust Board's appreciation be extended to all staff involved. Members endorsed Mr. McNaney's comments.

Mrs. Dalzell thanked Director colleagues for enabling the production crew unfettered access and undertook to pass on Trust Board's appreciation to staff teams involved.

d. Safety Quality Visits – Non Executive Director Reports

i. Laboratories, Kelvin Building, RVH – 25 July 2019

Mr. Smyth presented a report of his visit to The Kelvin Laboratories on the Royal Victoria Hospital site. He said whist there are challenges with the current building he found staff to be highly motivated and focused on delivering a safe and efficient service for all service users. There was also evidence of focus on training and staff development.

Members noted the report.

ii. Cranfield, Muckamore Abbey Hospital - 19 July 2019

Mr. McNaney presented a report of a visit he and Dr Jack had undertaken in Cranfield, Muckamore Abbey Hospital on 19 July 2019. They had taken the opportunity to speak to patients, management, ward managers, doctors and nurses and had observed work on the wards. Whilst there was clearly substantial challenges staff were committed to delivering safe compassionate care for patients.

Members noted the report.

30/19 Chief Executive's Report

a. Emerging Issues

Mr. Dillon had no emerging issues to report.

b. Speaking Rights

Mr. McNaney invited Mr. Hanna to address Trust Board.

Mr. Hanna thanked Mr. McNaney for the opportunity to address Trust Board.

i. Muckamore Abbey Hospital

Mr. Hanna referred to the RQIA Improvement Notices (INs) served on the Trust in respect of Muckamore Abbey Hospital (MAH). He quoted minutes of public Trust Board meetings when assurance had been given that MAH patients were receiving safe, compassionate care. Mr Hanna then quoted comments from RQIA following unannounced visits to MAH raising issues regarding appropriate staffing levels, patient safety and care plans. Given the recent RQIA INs, Mr Hanna said the public would question who is right i.e. the Trust or RQIA? He referenced the fact the Trust had not challenged RQIA.

Mr Hanna said it was concerning that; RQIA had issued INs two years after the alleged incidents being reported. He also referenced the

PSNI had stated that MAH was the biggest safeguarding investigation of its time.

Mr Hanna contended that the Trust was not addressing the MAH issues given the RQIA INs and questioned what was a resigning matter for the Chief Executive and Directors?

Mr Hanna referred to RQIA reports dating back to 2013-14 raising substantive safeguarding issues, which should have raised alarm bells for further investigations.

Mr Hanna referred to the Trust policy regarding the installation of CCTV in MAH indicating that all patients and staff should have been advised of the CCTV being installed.

ii. Clifton Nursing Home - Runwood Homes Group

Mr Hanna referred to Clifton Nursing Home, owned by the Runwood Homes Group, and concerns raised by RQIA since 2013 including issuing of Improvement Notices in respect of patient medication. He asked how long this home will be allowed to fail to meet standards before action is taken.

Mr Hanna emphasised the importance of vulnerable adults resident in Clifton House being provided with safe dignified care.

iii. ADHD Assessment

Mr Hanna referred to a 10-year child who has been waiting 102 weeks for an AHD assessment. The child had been referred by the GP in 2017, when in primary 5 now in primary 7 the child's parents are frantic for assessment to be undertaken. Allegedly, the emergency waiting list could be a further 2 years. Mr Hanna stated that Trust staff had told the child's parents the service is in crisis. Mr Hanna emphasised the importance of early intervention for children with ADHD. In 2015, the waiting time had been 12 weeks and in 2019 children are waiting more than 102 weeks for assessment.

Mr McNaney thanked Mr Hanna and invited him to stay to hear the update reports from Directors in relation to Muckamore, which would answer many of his questions.

Mr Dawson asked Mr Hanna to share details of the child awaiting ADHD assessment and he would arrange to have the service investigate the case.

In relation to Clifton House, Mr McNaney asked Mrs Heaney and Mrs Owens to investigate the issues raised and report back to Trust Board. He stressed the commitment of the Trust to ensure that residents receiving safe, quality dignified care.

He also indicated that Dr Flynn, the author of the SAI report on Muckamore would also be making a presentation later on in the meeting and her comments would also address some of the issues raised by Mr Hanna.

c. Muckamore Abbey Hospital

Mrs Heaney referred to the 3 RQIA Improvement Notices and advised that an Acton Plans are in place to address the issues raised and there is on-going dialogue with RQIA.

Mrs Heaney provided assurance that MHA current patients were receiving safe, compassionate care despite many challenges the most challenging being workforce. However, she pointed out that whilst the number of patients had reduced over recent months workforce levels had remained unchanged.

Mrs Heaney provided an update on a number of actions taken by the Trust on the MAH site including the introduction of the Purposeful In Patient Admission (PiPA) appraisal, which improved communication across the multi-disciplinary teams for individual patients. Individual 7-day activity plans are in place for patients; every Ward Manager holds a daily safety brief and there are regular Leadership Walkrounds undertaken. A Weekly Governance meeting occurs to review the Safety Report, which provides assurance on a range of safety metrics. The appointment of Mrs Brenda Aaroy as Carers Consultant has rebuilt communication and dialogue trust with patients' families. A programme of regular social events involving patients and their families is in place.

Mrs Heaney advised that the Trust had engaged East London Foundation Trust (ELFT) as a Critical Friend and they had undertaken a three day visit to MAH site. The Trust was liaising closely with them regarding implementing their recommendations. The Trust was revising the Seclusion Policy in line with Mersey Care's policy, which was recommended as a model of best practice. She also advised that the use of seclusion had reduced significantly.

Mr McNaney asked about progress in addressing the RQIA INs relating to the development of an appropriate nursing workforce model.

Miss Creaney advised that a proposed staffing model had been shared with colleagues in the PHA and DoH; in the meantime, the Trust had revised the skill mix of nursing staff on the MAH site. Miss Creaney referred to the complex needs of patients with learning disability and advised a regional workshop was being held to consider the future workforce model to support them.

Following a question from Professor Bradley, Mrs Edwards advised that a robust action plan was in place to address the issues raised in

the RQIA IN relating to patients finance. She pointed out that there were no concerns regarding financial miss-management, the issues related to processes not being followed. A series of training sessions had been held for MAH staff regarding awareness of the financial procedures and record keeping in relation to patient monies.
Mr Smyth said that as Chair of Audit Committee, Mrs Edwards had fully briefed him on the actions being taken in relation to financial management of patients' money and he was assured issues were being addressed.

Mr McNaney asked if the work would be completed within the timescale for the RQIA INs to be lifted.

Mrs Heaney advised that she was confident the issues within the responsibility of the Trust would be addressed, however there were some areas requiring regional input, outside the responsibility of the Trust. However, she was hopeful the issues would be addressed in a timely fashion.

Ms O'Reilly said she continued to be assured the Trust was committed to involving families in addressing the MAH issues. The engagement of ELFH provided expertise to assist the Trust in implementing change within the service. She also welcomed the involvement of carers in the DoH work, which demonstrated carers could influence services for the future.

Mrs Heaney advised that she and colleagues had met with RQIA to share progress against the Action Plans and RQIA had acknowledged a significant amount of work had and continued to be undertaken.

Mr Dillon advised that Dr Jack had agreed with the Medical Director of the RQIA that there would be regular monthly meetings between Trust and RQIA to report on progress against the INs and for assurance that the Trust was on track to have the INs lifted by 16 November.

Dr Jack said that patients on the MAH site were receiving safe compassionate care, personal activity plans were in place and there was regular contact with carers.

Dr Jack acknowledged that recent media coverage had been challenging for staff and support had been put in place.

Mr McNaney emphasised the importance of the PSNI completing their investigations quickly, which would permit the Trust to complete its disciplinary investigations.

- **Dr Margaret Flynn, Chair SAI Panel**

Mr McNaney invited Dr Flynn, Chair of SAI Panel to report on her recent review visit to MAH and to update the Trust Board on changes since the SAI review.

Dr Flynn then addressed the Board and stated she wanted to be candid in highlighting a number of issues and take a broader systems view of some of the issues.

Dr Flynn quoted the MAH website which states: *There are a number of people living in hospital who do not need to be there. They are waiting for community living arrangements to be funded so that they can leave hospital.* She said this statement underlines a principal finding of the 2018 review concerning safeguarding at MAH, she emphasised safeguarding could not be seen in isolation since custom and practice are shaped by the Hospital's history and culture, by BHSCT and the histories and cultures of other Trusts, the DoH and the Legislative Assembly. MAH is an isolated hospital, which is disconnected from community services. It is based on an acute-care model that does not work for people with life-long support needs.

Dr Flynn stated that for too many years, MAH has not been center-stage in the deliberations of the Legislative Assembly, DoH, HSCB, RQIA, or Trusts. She emphasised the case for major change must include all, from the Legislative Assembly downwards (i.e. politicians, Trust directors, Board members and inspectors) and must engage with people with learning disabilities and their families if they are to address the absence of home-treatment, supported living and provider expertise. All of these are associated with crisis admissions, which should be time limited.

The absence of proportionate incident reporting to the PSNI was the direct consequence of the HSCB's regional adult safeguarding policy and procedures. The frequency of the PSNI's attendance was not the result of out-of-control criminality; it was the result of a rigid policy requiring staff to report everything.

The PSNI is continuing their investigation and staff suspensions are the result of scrutiny of massive number of hours of CCTV films captured by 90 cameras.

In parts of the hospital, work practices in 2017 were harmful and disproportionate; for example, the intensive use of seclusion was not challenged. Dr Flynn pointed out that the low ratio of registered staff to patients was not a factor in those areas of the hospital where CCTV evidences patients being harmed.

Dr Flynn advised during December 2018 she had accompanied Mrs. Heaney to meetings with families to share copies of the SAI Review report she had chaired, following which she had shared the following observations with Mrs. Heaney:

- Some families revisited their experiences of caring for their daughters and sons before they were admitted to the MAH. Their accounts demonstrated their life-long commitment to their adult children, a deep desire to demonstrate their worth to others and a common singularity of purpose that they should not be harmed.
- Families shared the ways that they see their relatives and the ways in which they had negotiated their family lives. Their descriptions do not use the language of professional carers and are remote from the negative associations of "challenging behavior."
- Family routines involved parents dividing their time between their disabled adult children and their non-disabled children. Some explained that in the family home they were unable to eat together as a family or even be in the same room.
- Their loved ones admission to MAH was a major and distressing life event. It did not herald the end of family caring, but the beginning of very stressful times, as visits were not reassuring. Some envisaged entering into collaborative relationships with staff and sought to share their knowledge of their adult children, their biographies and preferences with ward managers and staff. This was not always valued. Although the families were keen to state that there are individual staff who "go the extra mile" and those who are "advocating strongly" on behalf of their relatives, they all acknowledged that their trust in professional managers and staff was eroded.
- The families described a range of scenarios, which they could not fathom. Decision-making appeared arbitrary and beyond negotiation. Some changes in their daughters and sons' lives were abrupt and promises concerning discharge placements were not realised.
- Increasing doses of patients' medication troubled families.
- The families' low expectations of MAH were realised. The efforts of "some brilliant staff" were overshadowed by the emergence of the CCTV footage and the PSNI investigation. The PSNI had visited most families and so some family members had seen images of their relatives being harmed.
- The families' aspirations are modest: "you have to take your moments – X has had a hard deal in life…to have a better life…to see X settled…to be able to visit and have dinner with X…the right people and the right environment, effective boundaries…supported by people who will treat them like family… a more hopeful future…"

Dr Flynn referred to the Permanent Secretary's statement "….. *action is urgently needed by the health and social care system as a whole…no one should have to call Muckamore their home in future, when there are better options for their care…Muckamore will return to being a hospital providing*

acute care, and not simply a residential facility....I fully recognise that the December 2019 deadline for the resettlement process will be challenging, but the Department owes it to patients and their families to be demanding...I remain very concerned about the HSC system's current structures and attitudes regarding concerns and complaints from service users and their families. All too often, it seems the onus is on citizens to persuade the system that something is wrong."

Dr Flynn reflected on an evening meeting hosted by BHSCT in February 2019, following which Mrs. Aaroy, Carers' Coordinator circulated a note of the discussion to families. The note set out a checklist of what families expect, i.e.:

- evidence of "honesty" and "action"
- not leaving problems unattended and contacts initiated by families without a reply; and ensuring that the lessons identified feature in the Trust's staff and management training
- reiterating clearly to the hospital and Trusts responsible for placing people how vital it is to listen to people with learning disabilities and their relatives; and to engage in ways which are mutually respectful
- purposeful engagement with families
- the clear intention to cease placing people in seclusion
- "better options" for people currently stuck at the Hospital
- ensuring that every family has information about who to contact in the event of any questions, objections or doubts they have concerning the care, support and treatment of their relatives
- staff members being required to "declare" whether or not they are working with relatives, in-laws and partners because this should not happen
- staff supervised by managers who are demonstrably engaged, knowledgeable, competent and accountable
- relatives being and feeling welcomed [it was acknowledged that "This has happened...It has changed already"]; and being respected as knowledgeable advocates and leaders
- a drive to improve the quality of community-based service provision that is planned on the basis of accurate information about individuals as well as being responsive to people's care and support needs
- precise RQIA registration and inspections which ask searching questions; evidence of a greater readiness to de-register homes which are failing people with learning disabilities and/ or have no track record in using information from families and knowledgeable front-line staff to achieve valued outcomes; a professional and credible response from the regulator when families report distressing events
- being respectfully offered timely information, most particularly when measures need to be taken in uncertain situations e.g. media coverage of events concerning our relatives.

Dr Flynn referred to a Trust adult safeguarding event for staff she had participated in. The purpose hinged on safeguarding practice. "Loss of focus" was a recurring theme. It was recognised that dovetailing

safeguarding procedures with inspections, contract monitoring, Mental Capacity and other legislation, professional regulation, complaints, clinical governance, internal disciplinary arrangements and serious adverse incidents is a critical task for professional leaders across the region.

Dr Flynn outlined five levels and contexts of adult safeguarding – from the individual level the Commissioner of the service to the Legislative Assembly from attending to a person's immediate safety to regional policy to introduce legislation. It is clear that "safeguarding practice" alone cannot achieve these outcomes because the levels are interconnected.

Dr Flynn referred to the number of staff suspensions and disciplinary proceedings; the RQIA notices; monitoring of historical CCTV footage; drafting of a CCTV viewing policy; and the ongoing PSNI investigation. All of which had a destabilising impact on morale and the hospital's ability to recruit to the workforce. She said there was no sense that these interventions arose from a coherent, whole system approach where multiple organisations and agencies worked in a collective sense of responsibility to achieve the best possible outcomes for citizens with learning disabilities.

Dr Flynn advised she was disappointed to be advised that the numbers of MHA patients being discharged continued to be compromised by new admissions, including re-admissions. Since March 2019, the number of patients has remained at "around 60," irrespective of BHSCT's "statutory supported housing scheme" and plans to discharge almost 20 people.

Dr Flynn said that during her return visit in June she had attended ward reviews, which were illuminating and upbeat. The multi-disciplinary team ward processes provided information about patients over the preceding week. The MDT included nurses, day support staff, psychologists, psychiatrists and a pharmacist who were focused and receptive to challenge. Plans concerning discharge arrangements were discussed in relation to each patient.

Dr Flynn noted patient's interests and activities are being advanced via activity plans. This is a significant improvement since the previous year given that the lifestyles of many adults with learning disabilities resemble those of sedentary older people.

Dr Flynn stated there has been a sea change in communications with carers and an observed readiness to make person-to-person contact with the hospital's managers – which can only be enhanced by the new Carers' Forum, co-chaired by a relative. Families need the reassurance that the provision of supported housing is changing the lives of discharged patients.

Dr Flynn said if there is a regional commissioning model concerning the support of people with learning disabilities and autism over the life cycle, its priorities remain to be set out. Adults with autism appear to be

especially vulnerable to being overlooked since there are so few providers with expertise in delivering valued support in Northern Ireland. She referenced the MAH's website, which is a stark reminder that BHSCT cannot deliver community placements. Hospital managers are striving to promote resettlement, maintain safe staffing levels, keep patients occupied and active and repair relationships with families, without promoting the MAH as "the default placement" which, remarkably, is how it continues to be perceived by some commissioners.

Dr Flynn advised that in July 2019 she had been disappointed to learn the upbeat references to "collective commissioning" during 2018 and the importance of taking collective action had no impact on MAH or those who were being returned to MAH due to "failed" placements. Although the WHSCT and SHSCT have Assessment and Treatment Units, BHSCT, NHSCT and SEHSCT have relied heavily on access to MAH. Meetings with managers responsible for "procuring" community services in three HSC Trusts confirmed that work with the Learning Disability Forum, for example, does not connect with the "ad hoc" purchase of services. Some providers have increased fees by as much as 40%. This has not resulted in improved services. Closer notice needs to be paid to whether what is being commissioned is value for money. There is no consensus on the way forward with some investments taking months to expedite and there are issues when people move from one Trust to another regarding what services they can access.

Dr Flynn stated there is no procurement as such, with commissioners looking to providers to come up with solutions and options. There is anxiety about the loss of the MAH because of the limited provider portfolio in Northern Ireland.

Dr Flynn referred to the all-purpose services of "day centres", which are out of step with people's aspirations, with considerable resources in transporting people at the beginning and end of each weekday. Yet these are critically important for families of people who would struggle to manage in the absence of this form of support. She had spoken to Managers who were seeking a Departmental commitment to the outcome of the Regional Adult and Learning Model; clear pathways in and out of acute, specialist provision, security of tenure for people moving into supported accommodation, consequences for providers who take patients and then quickly return them to hospital, greater investment and flexibility from housing providers and he support of society in demonstrating collective responsibility to house people with learning disabilities within communities.

Dr Flynn pointed out that the Carers' Coordinator is attuned to the fragility of families, particularly those who were assured of placements, which did not materialise or were terminated within weeks. The investment in working with families is integral to developments at the hospital because their involvement is enduring and changing. Many spend a great deal of time visiting their relatives.

Dr Flynn referenced the RQIA IN issued in August concerning staffing and nurse provision, adult safeguarding and patients' finances. Alongside this the PSNI reported "1500 crimes" had been committed within the Psychiatric Intensive Care Unit with a Detective Chief Inspector was quoted as describing this as PSNI's "largest adult safeguarding case of its kind." The RQIA's actions and the PSNI claims have placed an unreasonable burden on patients, their families and staff. The Stephen Nolan show of 28 August devoted part of the morning programme to MAH specifically the "1500 potential crimes." He asked: "why did the Hospital install CCTV if it did not intend to use it immediately? Whose job was it to view the CCTV? Are people at the top of BHSCT still going to work? Is there any accountability?" Dr Flynn said it was important that peoples questions should answered.

In concluding her presentation, Dr Flynn made the following points:

- BHSCT should respond to the allegations made in the media, initially to the families of patients who remain in MAH and to those who have left during the last two years. It should be clear about the actions (i) it has taken (ii) the MAH has taken since the CCTV images were viewed. Openness about the actions taken are paramount
- Muckamore Abbey Hospital requires a redefined *Statement of* Purpose hinging on the assessment and treatment for people with learning disabilities and autism with mental health problems. It has never been a single-purpose Hospital providing acute care
- a closure date and programme leading to this for Muckamore Abbey Hospital remains to be set out. It is essential that this decision involves people with learning disabilities and their families
- as an interim measure consideration should be given to NHSCT and SEHSCT being allocated their own acute care resources – separate buildings on the MAH site for which these Trusts have total responsibility in terms of admission and discharge, staffing and therapeutic input. This will "shadow" the creation of specialist, short term facilities within their own Trusts
- an acute care resource for the BHSCT should be in Belfast
- in the event of RQIA issuing further notices, the MAH should draft a Business Contingency Plan addressing (i) Hospital closure and (ii) transfer of responsibility for the MAH from the BHSCT
- A bold and well formulated regional effort is required. It must be pursed with energy and persistence at all levels, by Belfast Trust, by other Health Trusts, by providers, self-advocates, commissioners and families, by the DoH and society

Mr. McNaney thanked Dr Flynn for her very comprehensive feedback and agreed the importance of a regional agreement for a more appropriate care provision for people with complex learning disability needs.

Professor Bradley acknowledged the improvements the Trust had put in place for MAH patients. However, he referenced the need for issues to be addressed at policy level and the importance of the regional review

ensuring future services are flexible to meet the complex needs of people with learning disabilities.

Ms. O'Reilly stated the learning disability service needed to be commissioned differently. She was particular interested in feedback from families and emphasised the importance of them being included in the development of future services given their lifetime committed to caring for their loved one.

Mrs. Karp thanked Mr. Hanna for his comments earlier. She said she was grateful for Dr Flynn and ELFTs external challenges in respect of improving services. She said that she was assured that MAH were currently receiving safe compassionate care. Governance processes had been strengthened and whilst MAH wasn't the ideal setting for people with complex learning disabilities, for the short-term it was important it continued to care for these patients to allow more appropriate care pathways to be developed.

Mr. McNaney thanked Mr. Hanna for attending the meeting and sharing his concerns and asked him if he had any refractions on Dr Flynn's comments.

Mr. Hanna said it was important BHSCT liaise with relevant Directors in other Trusts regarding the discharge of patients. He reflected on his personal experience, his brother with learning disabilities attends a day centre and recently due to staff shortages, he had been unable to attend. He stressed the need for understanding of the impact this has on people with learning disabilities, to have their routine changed. He also referred to recent media coverage regarding the change in role of the Chair of Division and stated the need for communication with families so they don't learn of such changes in the media.

Mrs. Heaney advised that she is in regular contact with Director colleagues in other Trusts regarding a discharge programme for patients in MAH and the future care model for people with complex learning disabilities. In addition, Mrs. Heaney advised that herself and colleagues liaise very closely with families to keep them appraised of issues relating to MAH.

Mr. Dillon advised that the issues raised by Dr Flynn were being considered by the DoH Assurance Group. He stated that it was important that MAH continues to provide safe compassionate care for patients pending appropriate discharge arrangements and a regional view on future of Intellectual Disability Hospitals. However, he advised contingency arrangements were being drawn up for BHSCT patients in the event of the nursing workforce becoming unsustainable. He emphsised the overriding priority and preferred option is to stabalise the service in the interests of the patients.

treated, discharged or admitted within 4 hours and 12 hours; Hip Fractures 48 hours; Diagnostic – tests reported within 2 days, 9 weeks and 26 weeks; Cancer Urgent 62 day pathway; Out-patient percentage waiting no longer than 9 weeks; number waiting longer than 52 weeks; IPDC patients waiting no longer than 13 weeks; number waiting longer than 52 weeks; CAMHS and Psychological Therapies 9 / 13 weeks; AHP patient waiting longer than 13 weeks to first treatment; Complex patient discharge – 48 hour and 7 days.

Mrs Stoops advised that in addition to the CPD standards and targets, the Trust is monitoring trajectory plans as agreed with the HSCB in relation to 16 areas, of which 13 are being delivered, or substantially delivered, and 3 are not currently being delivered i.e. ED patients treated, discharged or admitted within 4 hours (RVH site); Diagnostics 9 weeks; and CAMHS 9 weeks

Dr Jack pointed out that in some areas the trajectory figures can be misleading as they do not demonstrate service improvements.

Mr. McNaney referred to the need for realistic targets to demonstrate the Trust activity against capacity.

Professor Bradley referred to a Chairman's Award Visit to a staff team who had reorganised CT scanner rotas, which had resulted in reduced waiting times and suggested learning could be shared with other specialties in respect of managing waiting lists.

Ms Stoops advised that learning and best practice is shared across services.

Mss Stoops advised that the Performance Framework was currently being reviewed.

Members noted the performance report.

b. Rural Needs Annual Monitoring Report 2018/19

Mr McNaney welcomed Mrs Barron to the meeting.

Ms Stoops presented the first Rural Needs Monitoring Report for the period 2018/19, providing an overview of how the Trust has fulfilled its legislative obligations in accordance with the Rural Needs Act (NI)(2016).

Members noted the reported detailed the: Description of each Activity that was subject to the Act; the policy area that the Activity relates to; and narrative description to evidence compliance with the Act.

Ms Stoops advised that Rural Needs due consideration has been undertaken and has limited relevance to the policies/service delivery that the Trust has undertaken during this reporting period. Whilst 145 policies

b. Neurology Review Update

Mrs. Owens provided an update in respect of the Neurology Review.

Members noted the position.

c. IHRD

Mr. Dawson provided an update on the on-going work in respect of the IHRD workstreams. He advised hat arrangements were being made for a stocktaking to be held in November for Trust staff.

Members noted the position.

d. Infected Blood Inquiry (IBI)

Mrs. Leonard advised the last round of this phase of IBI public hearings for the infected and affected was scheduled to commence on 8 October in London. The Inquiry will publish witness lists in advance; a significant number of individuals are giving evidence anonymously.

Members noted, as was the case with the Belfast Hearings, the Inquiry will not give the Trust advance notice of witness statements from those giving evidence at the Inquiry. The Inquiry have advised that statements will be published electronically on the website for Core Participants one week in advance.

Members noted the position.

j. Annual Report 2018/19

Mr. Dillon referred to the publication of the Annual Report for 2018/19, the draft of which had previously been considered at the confidential Trust Board meeting in June, together wit the annual accounts.

Members noted the publication of the Annual Report for 2018/19.

31/19 Safety and Quality

a. Performance Report

Ms Stoops presented the Performance Report for the period April to July 2019 providing an update on activity in respect of the Safety Quality and Experience over a range of indicators and performance against the DoH commission Plan Direction (CPD) standards and targets for 2019/20 and Trajectories agreed between the Trust and HSCB.

Members noted of the 34 DoH CPD standards and targets reported 13 are being delivered or substantially delivered, 3 are to be confirmed and 18 are not currently being delivered i.e. HCAI – MRSA and C.Difficille; ED patients

were subject to an equality screening, 4 were considered to have a potential bearing on rural needs.

Members noted the report highlighted the Trust is committed to adopting a proportionate approach to rural needs when there is greater relevance i.e. in the delivery of regional services

Following consideration members approved the report for submission to Department of Agriculture Environment and Rural Affairs.

32/19 **Resources**

a. Finance Report – Draft Financial Plan 2019/20

Mrs Edwards presented the financial position for the period ending July 2019, together with the draft Financial Plan for 2019/20. She explained that at the end of July 2019, the deficit position for the Trust is £12.5m. This deficit would pro rata to give a FYE £37.5m, which is £7m higher than the residual opening deficit. This is indicative of the fact that not all savings are currently being achieved at this stage of the year and workforce management targets are currently not all being achieved.

Members noted the ongoing pressure in relation to recruitment continues in 2019/20 and as a consequence there continues to be an increase in nurse agency usage in the first couple of months in comparison to 2018/19, particularly in relation to off-contract high cost agencies, resulting in increased average costs. The Trust is committed to achieving its 2019/20 workforce targets and is therefore relying on directors to fully deliver their workforce targets. This will be monitored closely in the next few months to understand if this is a continuing trend.

In relation to the draft Financial Plan, Mrs Edwards advised that whilst the Trust reported a breakeven position in 2018/19, much of the in-year reduction in the Trust's opening financial deficit was attributable to one-off, non-repeatable measures and a substantial amount of non recurrent income. As a result, the Trust is facing a recurrent underlying funding deficit of £70.2m after accounting for recurrent savings commenced in 2018/19. This deficit is the opening deficit before accounting for new pressures in 2019/20 including inflation, demographic growth and other inescapable cost pressures, estimated at £5m, pay uplifts or new developments.

Mrs Edwards advised the HSCB indicative allocation issued at the end June 2019, included £33.7m recurrent funding against the roll forward deficit, £4.52m against 2018/19 emerging pressures and £5.6m against other pressures/anticipated income. This has resulted in a residual opening deficit of £26.25m, comprising £1.5m from the rolled forward 2018/19 deficit, £13.5m 2018/19 unachieved savings and £11.2m 2018/19 unfunded

cost pressures. In addition DoH, through HSCB, has also levied a new savings target comprising the Trust's equity adjusted share of a £42.85m regional general Trust savings target (£17.65m), a 49% share of an £8m regional secondary care pharmacy savings (£3.89m) and a 56% share of a regional £1.7m car parking target (£0.95m).

Mrs Edwards pointed out that it is anticipated the Trust will be able to achieve, through a mixture of recurrent and non recurrent measures, a total of £15m new savings against general efficiencies. The majority of these savings will be set against the unmet 2018/19 savings target with only £1.5m available to set against the 2019/20 general savings target. New pharmacy savings of £3.89m are expected to be delivered in 2019/20 giving total savings of £18.9m. The Trust must also continue to meet its workforce management target of £18m.

Members were advised the current HSC financial plan does not take account of emerging 2019/20 cost pressures. The Trust is already aware of a number of emerging pressures, including high cost cases and auto enrolment, but at this stage has not included them in the financial plan as they are yet to validated or require further direction from commissioners. HSCB has been alerted to a number of potential pressures.

Mrs Edwards advised that after taking account of the new funding, savings targets and plans there is a residual net 2019/20 deficit of £30m, the Trust does not believe that this is achievable in-year without resorting to service impact measures. She emphasised the he Trust continues to explore all opportunities for efficiency and productivity savings or cost containment. A workshop has been held with key clinical and management leaders to review high spend areas and opportunities emerging from quality improvement work and comparative analysis with other Trusts. Following this a number of workstreams have been identified and task and finish groups established to take forward savings initiatives.

Mr Dillon advised the Permanent Secretary had written seeking assurance that the Trust would achieve all financial statutory requirements within 2019/20.

Members expressed concern at the financial position and current impact on waiting times for patients, which would be further impacted upon.

Mr McNaney acknowledged the difficulties facing the DoH and the overall allocation of funding to health from the Northern Ireland bloc grant, however he express the view that if savings need to be made, Trusts should act together and adopt measures, which had the least impact on the vulnerable.

Mrs Edwards explained she had to leave Trust Board early to meet with DoH colleagues to appraise them fully of the Trust position prior to responding to the Permanent Secretary. She undertook to provide an update at the next meeting.

b. Major Capital Projects

Mrs Edwards presented a summary report in relation to the on-going major capital projects as follows:

- **Acute Mental Health** – services to transferred the new in unit June, there are some building related issues to be addressed.
- **Maternity Hospital** – the Trust is liaising with DoH to secure additional contingency monies
- **Children's Hospital** – CPD-HP have alerted the Programme Board to an additional year for construction, the financial consequences have been requested
- **Critical Care Building** – the Project Boar have agreed to delay the theatre programme to coincide with the completion of the hybrid theatre to avoid any disruption to services
- **Helipad** – contractor replaces part of the system, NIFRS checking to ensure adequate water supply for fire suppression.
- **RGH Energy Centre** – significant delays in the planning approval process have had an impact on the programme.
- **Glenmona** – approval for the business case for the replacement of two units on the site i.e. an intensive support unit and separated minors unit.

Members noted the report.

c. Claim Under the Late Payment of Commercial Debts (Interest) Act 1998

Mrs Edwards advised the Board had previously requested her to seek legal advice from an independent QC, on a long standing matter in relation to monies claimed on behalf of Surgical Systems Ltd and an individual. She stated that legal opinion had been received from the QC and that it was clear the purported late payment claims were statute barred and the Trust's decision not to pay interest and compensation should remain as stated in earlier correspondence to Surgical Systems Ltd and the individual concerned.

Mr. Smyth confirmed that Mrs Edwards had shared the legal advice with him as Chair of the Audit Committee and he was happy to accept the advice. Mr Dillon also confirmed he was happy with the recommended course of action.

Members of Trust Board endorsed the decision proposed by Mrs Edwards.

d. Charitable Trust Fund Applications

Mrs Edwards presented the following Charitable Trust Fund (CTF) applications for final approval:

- Oncology – modification to the Acuity Room, Radiotherapy Department
- Neurosurgery Ward – purchase a spinal operating table

Mrs McKeagney advised the Charitable Trust Fund Committee had considered and approved both applications.

Members formally approved the above CFT applications.

33/19 Assurance Committee

a. Minutes – 30 April 2019

Mr McNaney presented the minutes of the Assurance Committee meeting held on 30 April 2019 for information.

Members noted the minutes

b. Terms of Reference – Annual Review

Mr McNaney presented the Terms of Reference (ToR) of the Assurance Committee, which had been subject to annual review, with no revisions.

Members approved the ToR.

34/19 Social Care Committee

Ms O'Reilly presented the Social Care Committee Adult and Social Care minutes of the meeting held on 29 November for information.

Members noted the minutes.

35/19 Any Other Business

a. Pseudomonas – Neonatal Unit

Miss Creaney advised on 3 cases of pseudomonas within the Neonatal Unit. Whilst not an outbreak the situation had been managed as one by the IPC Control Team, with hand hygiene audits undertaken and water and equipment tested.

Mrs Karp said this raised the need for all staff to ensure they adhere to Infection Control Protocols.

Members noted the position.

36/19 Date of Next Meeting

Members noted the next meeting was scheduled for 7 November 2019.

6.085

May 2019
Volume 1, Issue 1

News from Muckamore

CHERRY HILL TO OPEN

What a whirlwind few months!

Everyone has been working so hard on the development of this project that the end of the first phase is in sight!

All nine "home from homes" are completed and awaiting sign off from the Trust estates department. Paving has been replaced, everything internally has been repainted, baths and showers replaced where needed, new kitchens and white goods installed, fences repaired and curtains and blinds fitted.

All these properties need now, are their forever friends!

Eight of the properties have been matched with someone from the list of referrals received, and the final decisions on the ninth property will take place in the next couple of weeks.

Some resettlement meetings have already taken place, with many more planned in the near future. As the manager of Cherry Hill, I want to ensure that the needs of all the service users are assessed and met when they move into their new homes.

The staff team have been appointed and a three-week training programme will take place in June, to ensure that all mandatory training has been completed before "in reach" work with the service users begins. I am looking forward to meeting the service users

By Lisa Cathcart

What's On

Saturday Movie time
now a regular feature at 3.15pm in Portmore Training with popcorn!

Wee Critters
(Interactive Animal Education) spiders, snakes all sorts: Monday 24th June at 2pm and Monday 29 July at 2pm

Calendar of events

Multi-denominational Services (Moyola Gym) take place on alternate weeks Thursday at 1.30pm and Friday at 11am

Mass on Saturdays at 3.30pm

Dialectical Behaviour Therapy Club *(DBT club)* Tuesday evenings 6—7pm. Open to patients in Cranfield wards

Patients' Council, *Tell It Like It Is (TILII)* - Alternate Monday afternoons.

LD Pride Parade, Saturday 22nd June. Carrickfergus. Anyone interested in attending please contact Caroline McMenamin.

TELL US HOW YOUR VISIT WENT

We want to hear your thoughts

All wards, Moyola Day Care, Cosy Corner and the swimming pool, now have a box where families can give us feedback after their visit to their relative. Look out for the cards and drop us a note. It matters what you say and we will be using this feedback with the wards to focus on improvements but also to give positive comments. Thank you for taking the time to complete the cards.

Visitors' views matter to us!

FAMILY CARER INFORMATION BOOKLET

The new family carer booklet is now ready and you can receive your copy from the ward staff or access online on the Belfast Trust Website :

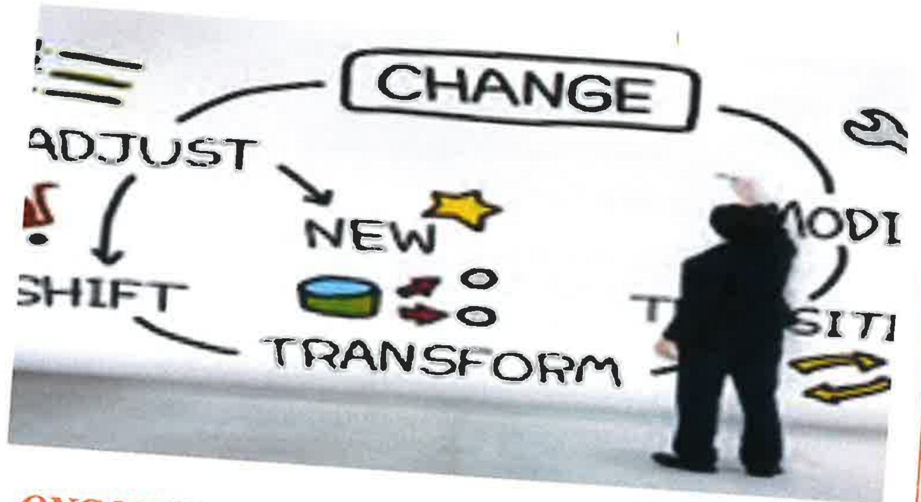
www.belfasttrust.hscni.net/LearningDisabilityService-MuckamoreAbbeyHospital.htm

New Muckamore Carers' Forum

Information

We have established a Muckamore Carers' Forum which is chaired by the co-director and co-chaired by a carer, Brigeen McNeilly. The forum will look at increasing family engagement and involvement in improving services. This forum will also have representatives from staff in Muckamore and as we go forward we will include representation from other trusts. Meetings have been planned for the rest of the year and will be held in Moyola Library on June 3rd, August 5th, October 7th and December 2nd from 3-5pm. This group will support improvements in services at the hospital, including the resettlement plans for patients. It will also link closely with the new Regional service model for learning disability. All families are welcome to participate. Please contact Brenda Aaroy on email

brenda.aaroy@belfasttrust.hscni.net or phone 028 95049769 for more details.



ONGOING CHANGES WITHIN THE BELFAST HEALTH AND SOCIAL CARE TRUST AND LD SERVICES

New Regional LD Project

The New Regional Service Model Project for people with Learning Disability has just been launched and our own Rhona Brennan, formerly of Erne Ward, will be the project lead for the Belfast Trust in partnership with the Health and Social Care Board. We congratulate Rhona on her new position and look forward to the plan of work in six particular areas; transitions, supporting families and service users, meaningful lives and citizenship, accommodation, health and wellbeing and assessment & treatment. There will be opportunity for everyone to be involved in engaging in this important work from frontline staff, to family carers and our service users. If you would like to be involved in the project then contact

Rhona.brennan@belfasttrust.hscni.net or 028950402513

PIpA – Purposeful Inpatient Admission

Dr Joanna Dougherty, Clinical Director Intellectual Disability Services and Breige Connery Muckamore Service Manager, are busy working with the hospital team, on setting up a pilot of PI-pA at Muckamore. This will help us improve patient outcomes and make the work of the Multi Disciplinary team more effective. The patient's journey will be mapped on a Visual Control Board from admission to discharge with visible reminders of the tasks to be undertaken and who needs to carry them out. Experience from mental health wards, where it has been used, has shown the success in improved team communication and a more cohesive approach to patient care, through formal measurement on defined outcomes. We look forward to hearing more about the launch plans and we will be engaging with patients and family carers on the ward for feedback during the process.

L'ARCHE Community Roots

Community Roots is a 26 week education programme supported by BHSCT Occupational Therapy staff and staff from Root Soup, L'Arche. Community Roots is designed to increase participant's awareness of healthy lifestyle and provides practical skills based training in growing, preparing and cooking food. It is on every Friday Afternoon

Church

Rev Paul Redfern supported by SLT facilitates church every week.

Thursday afternoon one week and Friday morning the other week.

THERAPY BOXS

Joint Therapy Aims and Free time Plan/Activity Box

The purpose of the Joint Therapy Aims is to work effectively as a multidisciplinary team and reinforce therapy and treatment for our patients. Creating a Free time Plan/Activity Box then allows ward staff to work on these therapy aims with the patients and be an important part of their treatment. It also keeps patients occupied and engaged in various activities that are recommended as part of their treatment and overall wellbeing. The box could also be used to deescalate a situation or redirect a patient from a difficult situation. This is in line with the Positive Behavioural Support model and it is hoped it will also be incorporated into each patients timetable for any 'free time' or 'down time.'

ONGOING EVENTS FOR PATIENTS

Therapeutic Day Services

The Therapeutic Day Service is a 7-day service, which includes evenings and weekends. Patients are referred by their ward and it is then assessed what type of day services/activities/opportunities would be most suitable. These activities can take place in the Therapeutic Day Service building, the Gardens, on the grounds of Muckamore, in the community or in the ward - depending on the patient.

Activities Available	
Arts and crafts Gym equipment Cookery/making food facilities Sensory trolleys – Moyola gym has black out blinds Foot massage Walks throughout the grounds Library – books and DVDs, Games and Puzzles Bikes and trikes Swimming TV/projector in gym	Table tennis Basketball Badminton Football Gardens Disco equipment Beauty – nails and hair equipment Tablets Bocce/Bowls Pool Tables Parachute Quiet Time – open, spacious environment with a variety of rooms

Social Farming and Extern also provide services to patients throughout the week. Everyday Harmony provide music therapy

EVENINGS AND WEEKENDS

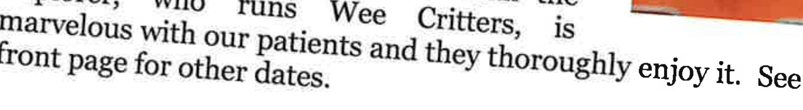
Over the summer all of the activities and day opportunities that have started will continue, such as Mondays pool night, Tuesdays drop in club, Wednesdays swimming, Thursdays street soccer and Saturday Gardening group with TCV and afternoon movies. Karen Diamond, Music Therapist and Maeve Cassidy, Artist attend the wards.

Bespoke packages for patients on evenings and on Saturdays and Sundays, when not facilitating groups, will also be offered—such as going for walks and drives

EVENTS FROM EXTERNAL PROVIDERS

Wee Critters

The Wee Critters' event in Moyola Day Care on the 13th May was a huge success, with patients thoroughly enjoying the armadillo, baby barn owl, baby turtles, baby hamsters, snakes and tarantula! Not for the faint hearted but many of our patients are as brave as lions as they handled all the creatures fearlessly and with gentleness. If you haven't see this great show then try to catch one of the next two. Allan the Explorer, who runs Wee Critters, is



marvelous with our patients and they thoroughly enjoy it. See front page for other dates.

Balmoral Show

The patients who attend Social Farming, visited the Balmoral

show on Wednesday 15th May and had a fabulous day! The day started with cheering on the farmer, Robert and his cow at the cattle rings. They came in 2nd place and later that day there was an even bigger surprise when the cow calved 2 weeks early and at the show! Patients browsed the stalls and collected bags full of free samples and merchandise, before watching Jason Smyth Adrenaline Tour Stunt Show. One of our patients even won a t-shirt at the stunt show. Picnics were had and then patients watched sheep shearing, walked around the grounds, engaged with the various stalls and entertainment act – including stilt walkers and a Robot! Patients then checked out the gardens and machinery. To end the day patients sang and danced to Derek Ryan. Staff who supported the patients also had a brilliant day. Patients commented that they 'loved it' and 'it was a great day.' Roll on Balmoral Show 2020!

DBT CLUB

DBT Club is a therapeutic group offered by the Psychological Therapies Team on a Tuesday evening to patients in the Cranfield Wards. The aim of the club is to revise and practice the key skills learned in Dialectical Behaviour Therapy in a fun, accessible way through games and activities. Skills such as mindfulness, coping skills, interpersonal and relationship skills are explored with posters, art and craft work, role plays, games and walks. This is also an opportunity for patients to socialize, get to know one another out of the ward environment, and to chat about their thoughts and feelings. The club enjoys regular attendance and members get to display their posters in Cranfield MDT room. The DBT Club is also offered on a Wednesday or Thursday morning/afternoon to patients in both Sixmile wards as part of the DBT 'Skill of the Week' programme. Both patients and staff get the opportunity to learn and practice essential DBT skills in these groups and maintain their DBT coping boxes.

The DBT Club Chronical (newsletter) is available on wards and was created by the group members.

By Laura McBride, Grainne Foss and Marcella Laird

Upcoming events to watch out for

Staff Celebration BBQ at Moyola ***June 14th, time to be arranged*** ...all families, patients and staff are welcome. Celebrate our hospital diversity and show how we value every person in it.

'Staff and service users at Belfast Trust represent a wide variety of people from many diverse backgrounds and situations. It is important that we deliver safe, effective and compassionate health and Social Care irrespective of race, gender, sexual orientation, religion, age, disability, political beliefs, marital status or dependent status.'

June 21st 2019 sees the 100th year celebration of Learning Disability Nursing

ONGOING EVENTS FOR STAFF

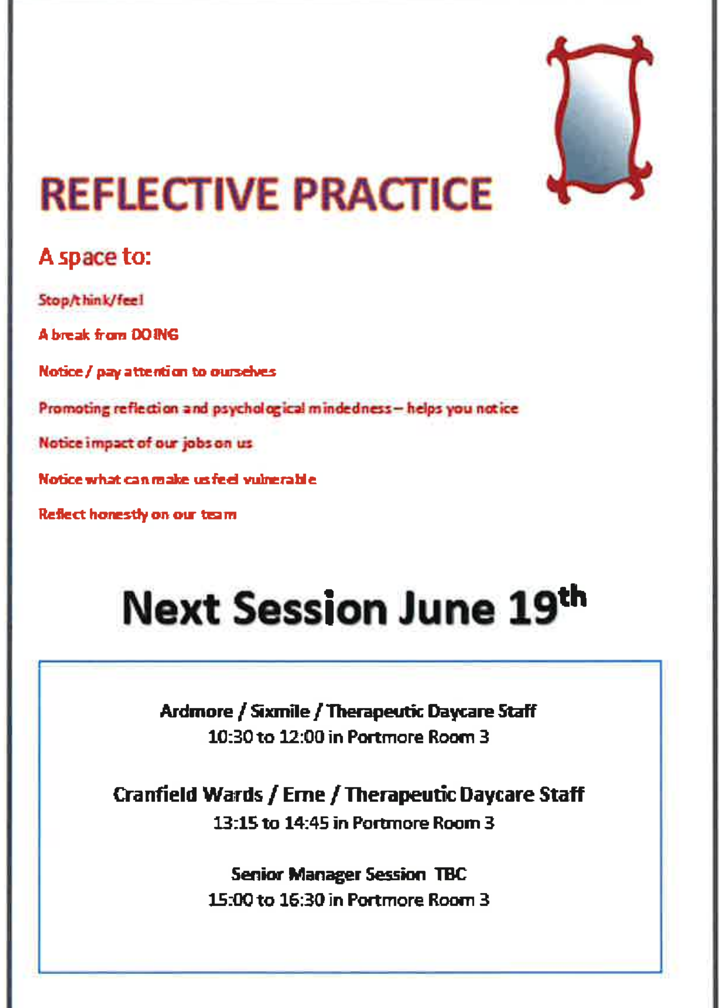
The B Well Fair

This will be a marvellous event with all sorts of pampering for well deserving staff. Many thanks to Brigene McNeilly for providing the reflexology.

Monthly Communication Briefings

A monthly staff communication event will now take place to increase information across the site. At the last event, we heard from Marie Heaney, Director of Adult, Social and Primary Care Services, Brenda Creaney, Director of Nursing, Sarah Meekin Head of Psychological Services, Colin Milliken Chair of Division Intellectual Disabilities and Rhona Brennan, Project Lead for the new Regional LD Service Model. It was a great opportunity to learn more about what is going on and ask questions. Watch out for the next email notification.

Reflective Practice Sessions For All Staff



Introduction of Behaviour Assistants

Several Behaviour Assistants are due to start early summer on the wards. This will assist with the implementation of Positive Behaviour Support (PBS) through direct work with the patients within the ward environment—watch this space for more information

Congratulations

Welcome back from maternity leave and congratulations to all our new mums. We hope your bundles of joy will bring you much happiness

Leaving

Sadly, we have long standing colleagues leaving Learning Disability services after many years of service. **Mairead Mitchell**, the Co Director of Learning Disability is retiring at the end of May and **Brendan Ingram** the Business & Performance manager is also retiring at the end of June. We wish them both a long and happy retirement. Marie Heaney, Director Adult, Social and Primary Care Services for the Belfast Trust will be on site, during recruitment of a new Co Director.

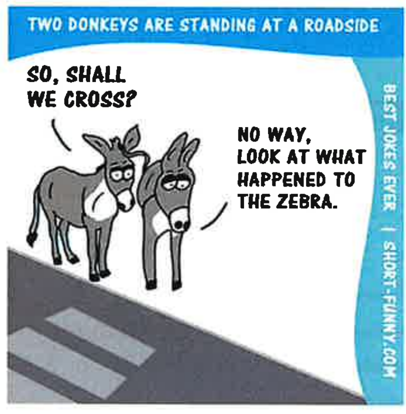
Family Carers using Moyola at the Weekends

Any family carers interested in using Moyola in the weekends with their relative please contact Caroline McMenamin for further information. Caroline's email address is available in the photographs section.

Muckamore Abbey Hospital
1 Abbey Road
BT41 4SH

THIS IS OUR FIRST NEWSLETTER

This is our first newsletter and we are hoping to issue one every couple of months. Everyone is welcome to contribute with a story and better jokes than this!!



Contact: Miriam.combe.belfasttrust@hscni.net or drop a contribution at the reception desk in Six Mile.

PHOTOGRAPHS

We would love to use more photos of our patients participating in activities so we are going to continue completing consent forms. Please contact

caroline.mcmenamin@belfasttrust.hscni.net or telephone: 028 95044053

if you need a form.

Contributors

Many thanks to **Grainne Foss** and **Caroline McMenamin** for all their work in putting this first publication together (we couldn't have done it without you) and to everyone who has contributed.

6.083

August 2019
Volume 1, Issue 2

News from Muckamore

Celebration Day

The atmosphere was a little bit busy at Moyola on June 14th but the excitement was palpable and with bunting, loads of lovely grub, music, crafts and entertainment, sure we couldn't go wrong. Well the weather could have been nicer but that didn't deter the fantastic participation by patients, staff and families that all turned up to have a great day out. The day was kicked off by the wonderful Equal Notes, the Learning Disability Choir from Belfast, who love singing and performing. Karen Diamond is their musical leader and the popular tunes got everyone warmed up. Staff members Alice and Davis prepared African and Indian food feasts and Billy Moore from the Muckamore Friends & Family helped man the barbecue. Everyone got to sample Chinese sweeties thanks to Dr Yeow and Norwegian waffles thanks to Brenda Aaroy! Entertainment continued with fabulous guitar playing and singing from Brendan Popplestone. Inside, we had art with Frank Holmes and Day Services Staff, and Chinese writing with Jennifer Wu. As with all these things, the preparation is key and the staff at Moyola did an outstanding job so thank you to all of this great team for their efforts. A big thank you also to the patients and their families for attending. Here's to continuing to build good, open communication between us all and to celebrate the great diversity on this site. More Pictures on page 12

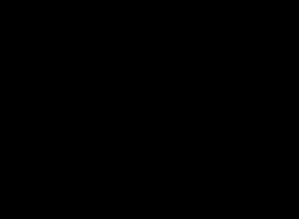
Cherry Hill - The Whirlwind Continues!

Our new staff team, myself included, have received our three weeks of induction training and have been completing in-reach work with the people we will be supporting to live in Cherry Hill. It's such a privilege to be working with the service users during such an important time in their lives and those of their families/carers.

We are so close to our first service users moving in and the teams are working hard to make sure that all goes to plan. The houses have been fully renovated and our staff team are ensuring that they are kept clean and tidy until their 'forever friends' get their keys.

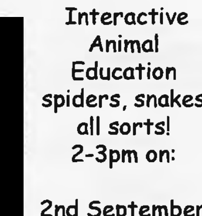
Resettlement meetings are taking place with increasing frequency. We are working in partnership with our colleagues in the hospital to make sure all needs are met and plans are in place to ensure the service users are happy and safe in their new homes.

By Peter Hoper, Deputy Manager, Cherry Hill



What's On

WEE CRITTERS



Interactive Animal Education spiders, snakes all sorts!
2-3pm on:

2nd September
30th September
28th October
25th November

'Celebrating Good Relations and Diversity' Tuesday 17th September from 12-2pm

Marie Heaney will hold the next Communication meeting on Wednesday 21st August from 12-2 pm in Moyola Gym.

Multi-denominational Service (Moyola Gym) takes place on Thursdays at 11am

Mass (Moyola Gym) takes place the 1st Saturday of the month at 3.30pm

Dialectical Behaviour Therapy Club *(DBT club)* Tuesday evenings 6—7pm. Open to patients in Cranfield wards

Patients' Council, *Tell It Like It Is (TILII)* - Alternate Monday afternoons.

Visitors views matter to us!

We want to hear your thoughts

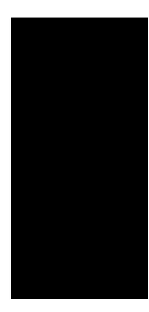
All wards, Moyola Day Service, Cosy Corner and the swimming pool, now have a box where families can give us feedback after their visit to their relative. Look out for the cards and drop us a note. It matters what you say and we will be using this feedback with the wards to focus on improvements but also to give positive comments. Thank you for taking the time to complete the cards.

MUCKAMORE CARERS' FORUM

We have established a Muckamore Carers' Forum, which is co chaired by Mairead Mitchell and family carer, Brigene McNeilly. This forum also has representatives from staff in Muckamore, including Kelly Anderson (Ward Manager), Caroline McMenamin (Day Opportunities Manager) and Breige Connery (Hospital Manager). We want to develop a strong family voice in improving the services that are delivered and this group is open to any family carers at Muckamore who would like to participate. As we go forward, we will also include representation from other trusts. Meetings have been planned for the rest of the year and will be held in Moyola Library on Mondays - October 7th and December 2nd from 3-5pm. We encourage and welcome all families to participate if they can. Please contact Brenda Aaroy on email brenda.aaroy@belfasttrust.hscni.net or phone 028 95049769 for more details.

ON 21ST JUNE 2019 WE CELEABRATED 100 YEARS OF LEARNING DISABILITY NURSING!!!! THANK YOU TO ALL OUR NURSES!

Danielle Quinn, Seamus Coyle, CJ McDonald and Sinead Lawler helped design the poster below as part of the Caring Cultures Programme – Foundation of Nursing Studies. Well Done!



CHURCH

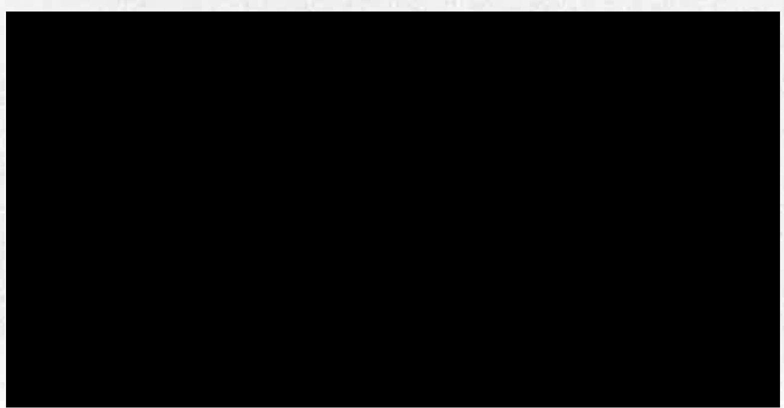
Rev Paul Redfern supported by SLT facilitates a multi-denominational Church service church every week **Thursday at 11am**

A NEW DIETETIC ASSISTANT, Sharon McGrady will join the Muckamore team in October for 2-3 days each week. Sharon is attending the 'I Can Cook it' training before she starts and will do the same training for our patients. This will assist our patients, who are getting ready for new homes, to learn about healthy eating and learn new cooking skills. Sharon welcomes any ideas from staff, patients and families in promoting healthy eating. Email: tracy.ferrier@belfasttrust.hscni.net

L'ARCHE COMMUNITY ROOTS

Community Roots was a 26 week programme supported by OT staff and L'Arche. It is designed to increase awareness of healthy lifestyle and provides practical skills based training in growing, preparing and cooking food.

CONGRATULATIONS TO THE PATIENTS THAT COMPLETED THE PROGRAMME AND GOT CERTIFICATES ON 2nd AUGUST 2019



WELCOME TO OUR NEW BEHAVIOUR ASSISTANTS!

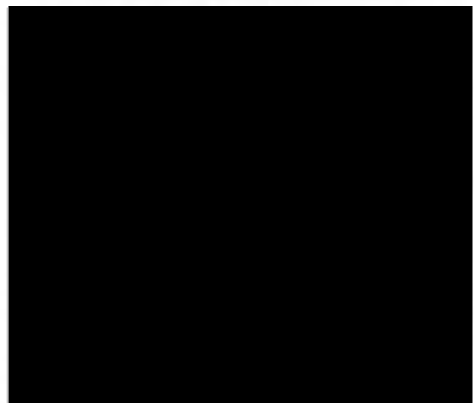
On 23 July, our new behaviour assistants started work on the wards. They have completed RAID (Reinforce Appropriate, Implode Disruptive) training. This is a consistently positive approach to working with behaviours that challenge. They have also completed Management of Actual and Potential Aggression training (MAPA).

The role is being piloted to look at how we can enhance the ward based staff resource and capability to promote the ethos of Positive Behaviour Support (PBS) and to deliver on the opportunities that promote quality of life and active skill development for our patients. The new staff will assist the Behaviour Specialist and ward team in gathering data for behavioural assessments and the completion and implementation of PBS plans.

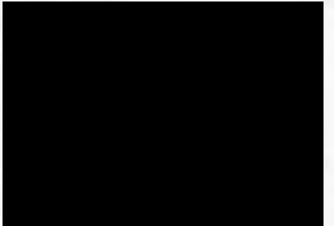
WHAT HAS BEEN HAPPENING FOR PATIENTS?

Birthday Celebrations

A special birthday needs celebrating properly and Mark enjoyed a lovely lunch with staff and family and this fantastic Tractor Birthday cake. Congratulations Mark on your special day!



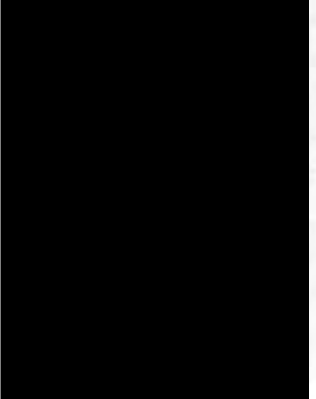
LEARNING DISABILITY PRIDE



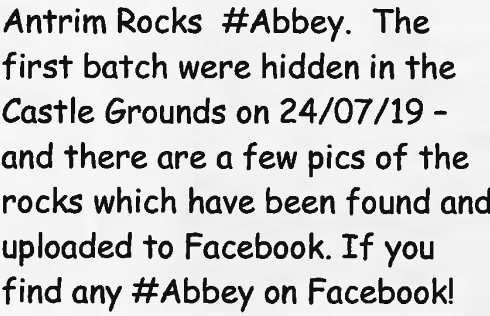
Learning Disability Pride is a celebration of people with a learning disability, which raises awareness and challenges stereotypes, with a focus on an inclusive and fun day out for families, individuals and groups. Our TILII members attended!

Carrickfergus 22.06.19

Well done to all the patients that attend Street Soccer. On 27th July 2019 they received medals and certificates for this, as well as Street Soccer hats. 2 service users from the community team came up to meet the patients and tell them about the community team. All the patients work so well with the coach Conor and have developed brilliant football skills!



ANTRIM ROCKS!



Patients who attend the Therapeutic Day Service have been taking part in this new craze! In June they went to collect the rocks at Drains Bay near Ballygalley and have been painting them since – they are identifiable with Facebook Antrim Rocks #Abbey. The first batch were hidden in the Castle Grounds on 24/07/19 – and there are a few pics of the rocks which have been found and uploaded to Facebook. If you find any #Abbey on Facebook!

WHAT HAS BEEN HAPPENING FOR PATIENTS?

Social Farming and the Antrim Agriculture Show

Patients have been engaging in Social Farming at Laurelview Farm since February 2019 —look what they have been getting up to...

We also had some of our Social Farmers at the Antrim Agriculture Show on 27.07.19 - showing the cows, calves and a dog with Robert the farmer, they won three 1st prizes and one 2nd prize! What a successful day all round!

Green Fingers at the Therapeutic Day Service

Patients have been getting stuck into the gardening over the last few months, working with Day Service Staff and The Conservation Volunteers, The Therapeutic Day Service had its assessment on 31.07.19 for the 'Best Kept Day Centre Gardens Award'...could they win it 2 years in a row? Well done to all the patients for their hard work, come have a look around Moyola to see their beautiful work in the gardens!

On Thursday, August 1st, we had a surprise visit from our Belfast Trust CEO Martin Dillon. He took time to visit all the patients and staff on the wards and in the therapeutic day services. He spoke with staff and thanked them for all their work. Staff really appreciated his positive feedback and couldn't believe how he remembered everybody's name! Thank you Martin.

TOAST

Total Outstanding Attitude, Service and Talent awards!

Danielle Quinn, on Six Mile, has been the genius behind the new TOAST initiative. It's a great idea for all of us to take a bit of time and recognise some of the exceptional work that our colleagues are doing. What has been wonderful about this, is our patients are also joining in! Well done Danielle! Patient comments about their nurses and support workers:

She is a really good nurse. She is always helpful. She always listens to me and helps me.'

' for being a kind and caring person and always get the crack on lol. She knows how to lift everyone's mood and good getting advice of'

Congratulations to Nurses - Alanna McCavana, Anna Cleland, Helen Ward and Ciara Cullen in completing their Forensic Short Course at University of Ulster

SYNERGY TRAINING

Two day **Synergy** training with Prof Richard Mills and Linda Woodcock on 6th and 7th August. Day 1 was attended by twenty four staff and day 2, eighteen.

AIMS

- Begin to change the way we think about what we call 'challenging behaviour'.
- Begin to change the way we think about and manage our own behaviour.
- Provide ideas and tools for taking this forward.

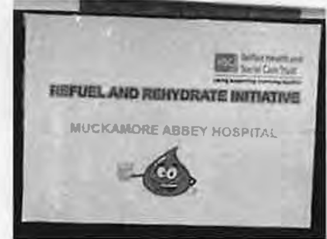
Look out for these cards around the wards!

Well done and thank you to the staff that helped out at the recruitment day, we had a successful day which was well attended.

STAFF RECRUITMENT DAY
20 JULY 2019
OLD SEA HOUSE, BELFAST

The B Well Fair

This was a good event to promote staff wellbeing! Hampers and water bottles have now been distributed to all our wards and are in use.



PiPA Pilot (Oisin McAuley)

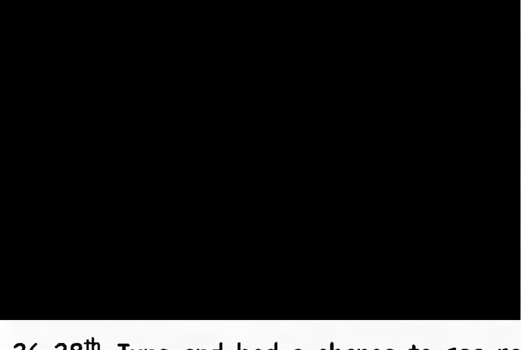
'The PiPA pilot **(Purposeful in Patient Admission)** has now been operational for nearly two months in Cranfield 1. We use it every day to track the progress of our patients from admission to discharge. Instead of a weekly and lengthy meeting of the Multi-disciplinary Team, this daily meet up is shorter and more focussed and makes sure actions are taken promptly. I think it has made roles & responsibilities clearer and follow up tighter. Communication between teams and effectiveness of the reviews have improved. We lock ourselves in a room at 9.30am every morning and use a visual display to track the progress of each of our patients and a task board for noting the actions that need to be taken and by who. It's my ambition that some of our support workers are also included to they have increased knowledge of the process but can also contribute valuable thoughts on patient care' Due to its success, the PiPA process has now been rolled out to Ardmore, our Female Admission Ward.

ONGOING EVENTS FOR STAFF

Monthly Communication Briefing

Marie Heaney will hold the next Communication meeting on Wednesday 21st August from 12-2 pm in Moyola Gym. All site teams are encouraged to attend.

Visitors



Staff from the East London NHS Foundation visited Muckamore from the 26-28th June and had a chance to see round our hospital facilities and our community services. Although their report is still pending, this was the beginning of developing a learning partnership with another NHS organisation and gave us both the opportunity to share best practices and look for improvements. We are planning a reciprocal trip to their facilities and look forward to building closer links. Feedback will be shared with all staff when we receive the report.

REFLECTIVE PRACTICE

A space to:

- Stop/think/feel
- A break from DOING
- Notice / pay attention to ourselves
- Promoting reflection and psychological mindedness – helps you notice
- Notice impact of our jobs on us
- Notice what can make us feel vulnerable
- Reflect honestly on our team

Dates from August 2019

Ardmore / Sixmile / Therapeutic Daycare Staff
10:30 to 12:00 in Portmore Room 3

Cranfield Wards / Erne / Therapeutic Daycare Staff
13:15 to 14:45 in Portmore Room 3

COUCH TO 5K — SIGN UP!!!

The Physiotherapy department and Therapeutic Day Service are going to team up to offer 'Couch to 5k' to patients. This will be a 9 week programme and tailored to patient's ability level (walkers welcome). There will be 3 sessions per week, one using the swimming pool. We hope to use MAH grounds but also different locations as the sessions progress. The proposed start date is on 13th August 2019 - times below.

- Tuesday 4pm (swimming session from week 2)
- Wednesday 4pm
- Friday 9.15am

NEWS

Mairead Mitchell is now back two days a week to support ongoing work with family carers in Muckamore and in the community.

Welcome back from maternity leave and congratulations to all our new mums. We hope your bundles of joy will bring you much happiness.

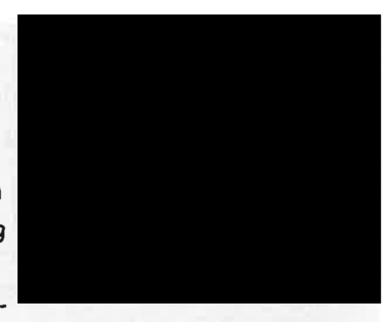
Warmest congratulations to Caroline McMenamin who recently tied the knot!

HARE COMPETITION

Who can get the best photo of a hare on site?

In celebration of our wonderful wildlife here send your best photo by 15th September to be judged as an entry to win a £20 gift voucher!!! Send entries to miriam.mccomb@belfasttrust.hscni.net

REGIONAL LEARNING DISABILITY IMPROVEMENT PROJECT

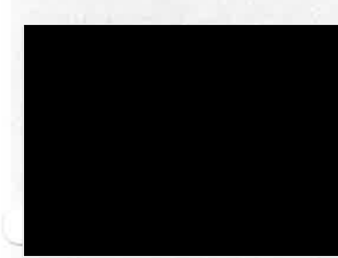


Belfast Trust Engagement with Family Carers

The Belfast Trust hosted a family carers' event in the MAC on June 18th to kick off the engagement in the new Regional Service Model Project for Learning Disability. Over two sessions, 55 families attended the discussions and a further 40 expressed an interest in being involved in this important work. On the day, families gave their opinions on what was working well, what wasn't and what could be done in the future for the six main themes of this project: Supporting families and service users, Meaningful lives and citizenship, Transitions, Accommodation, Health & Wellbeing, and Assessment & Treatment. This work will continue in September, when the Belfast Trust LD forum will be re-established, with staff, family carers and service users an integral part of planning the further engagement and input to these work streams. Engagement with staff is also key to this work and a workshop was held in Muckamore on 25th June, which was attended by 30 members of staff. Anyone else who would like to become involves in this process please contact rhona.brennan@belfasttrust.hscni.net for more details.

There is a Learning Disability Nursing consultation, on the project, being held in the RCN headquarters, Windsor Avenue, on Friday 9th August, 10am-1pm. All learning disability nurses are welcome to attend.

ONLINE SURVEY



In addition to the ongoing engagement meetings being undertaken across all Trusts in helping to develop a new model for adult LD services across NI, 3 surveys have been produced

(i) Service Users (2) Family Carers (3) HSC staff

The surveys are being hosted by the Department of Health (DoH) website, the surveys will be available from 5 August - 12 September 2019, here is the link:

http://www.hscboard.hscni.net/our-work/social-care-and-children/learning-disability/

If you want to go directly to the survey the links are below:

https://consultations.nidirect.gov.uk/regional-ld-service-model-review/service-user/

https://consultations.nidirect.gov.uk/regional-ld-service-model-review/staff/

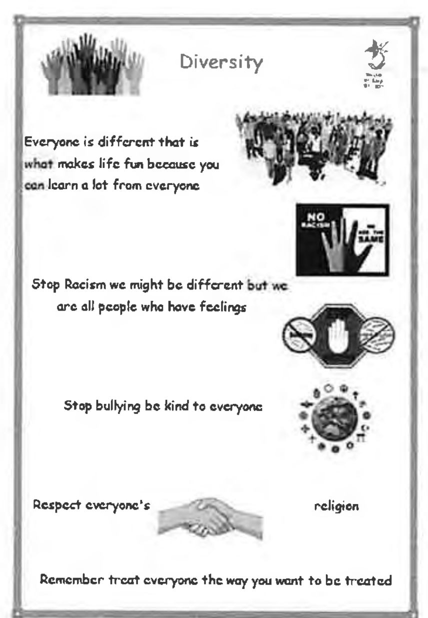
https://consultations.nidirect.gov.uk/regional-ld-service-model-review/family-carer/

UPCOMING EVENTS

'Celebrating Good Relations and Diversity'
Tuesday 17th September from 12-2pm

The Belfast Trust Good Relations week kicks off on Monday, September 16th. There are a range of events during the week but we will host an event in Muckamore on Tuesday 17th September from 12-2pm. The title of our event will be 'Celebrating Good Relations and Diversity'. The plan will be to launch the Equality vision, which is a short film on equality co-developed and produced by adults with a learning disability. There will be an array of music, dancing and food. All LD staff (hospital and community), are welcome as well as patients and families.

'Staff and service users at Belfast Trust represent a wide variety of people from many diverse backgrounds and situations. It is important that we deliver safe, effective and compassionate health and Social Care irrespective of race, gender, sexual orientation, religion, age, disability, political beliefs, marital status or dependent status.'



The TILLI group have worked very hard on this poster to promote Diversity!

Family Carers using Moyola at the Weekends

Any family carers interested in using Moyola in the weekends with their relative please contact Caroline McMenamin
caroline.mcmenamin@belfasttrust.hscni.net
Telephone: 028 95044053

What did the shark say when he ate the clownfish?

This tastes a little funny.

This is our 2nd newsletter and we are hoping to continue to issue one every couple of months. Everyone is welcome to contribute with a story and better jokes than this!!

Contact: miriam.mccomb@belfasttrust.hscni.net or drop a contribution at the reception desk in Six Mile.

Good Relations Statement

The Belfast Health and Social Care Trust wants to make all its services welcoming and safe places.

The Trust will make sure that all service users and staff have the same fair chance to use any of the Trust's services.

The Trust will treat everyone the same whatever their:

- Race

- Religion

- Political views

The Trust will work to challenge anyone who thinks that people should be treated in a worse way because of their:

- Religious beliefs

- Race

The Trust will help people from different religions, races and political views to live and work well together.

SAFEtember is a campaign to encourage all staff working across the Belfast Trust to have renewed focus on the safety and quality of all our services. Through a series of events and initiatives, the Trust will be promoting Safety and Quality Improvement in September https://view.pagetiger.com/Safetember2019/calendar

WHAT'S GOING ON IN THE COMMUNITY?

Belfast Trust community of staff, family carers and service users in our Day Centres (supported by our Speech & Language department and TILII), participated in an extensive engagement process, using a tool called Appreciative Inquiry. Appreciative Inquiry (AI) focuses on what is strong rather than what is wrong and helps everyone realise the best in our services as we plan for changes in the future. The exciting part of AI, is that you get to dream a bit and we used the Geni image to give everyone three wishes. This made the dreaming more fun.

Each of our eight day centres, now has its own plan for short, medium and longer term actions and here you can see how Fortwilliam staff and service users are pictorially tracking the actions they had decided to take. Sheena McGovern and Adrian Brennan of Fortwilliam sent me the photo below of their Live Wall. Service users at Fortwilliam decided they would like to show pictures of what has been done so far in their day centre, while celebrating their achievements. This has started conversations on things like assisted technology which are easier to understand through pictures.

Brenda Aaroy, Carer Consultant

I have been out and about among our statutory facilities within the Belfast Trust, which provide residential, nursing, supported living and short break solutions for service users and families.

I have met marvellous staff in all these facilities, who are providing outstanding care for service users, whether it is full time or part time. I have met service users who are sharing accommodation and others who have their own place and I have been taken round many tastefully decorated bedrooms, bathrooms and living rooms. I could well be calling on the services of very talented people, as each service user told me about how they chose their colours and furniture. I have had coffee made for me, spoons played for me, a lesson in mint growing and oh the stories of friendships, work (paid and voluntary), hobbies, housework and dinner parties!

Between the dedication and kindness of staff here in the hospital and those within the community, I am grateful to you all for choosing to work with our relatives with Learning Disability. Thank you

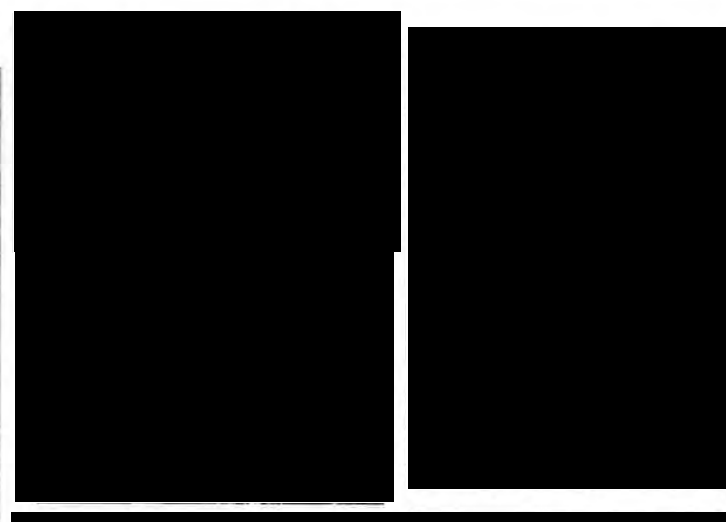
MORE PICTURES AND LOVELY COMMENTS ABOUT OUR CELEBRATION DAY!

Thank you so much for the food and a great day, Alistair enjoyed his time with us and the staff were great and patient. Agnes (Carer)

Thank you for the lovely day, me and my sister Rita had a great time, need to do this more often . Lorraine (Carer)

Thank you all for a lovely day, myself and son had a ball, would love to be able to do things like this again. Lorraine (Carer)

Mark and myself had a lovely afternoon, enjoyed the music and the food. Tracy (Carer)



Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust

Executive Summary

The Belfast Health and Social Care Trust asked East London NHS Foundation Trust for consultation because of problems at Muckamore Abbey Hospital for people with learning disability, including the alleged physical abuse between patients and staff, cultural concerns and issues with following appropriate seclusion procedures. We found many examples of good practice when we visited. However, the Belfast Trust recognises that there is an over-reliance on the use of inpatient beds for people with learning disabilities. Community services can often feel stretched, affecting their ability to be responsive, to focus on those with the greatest needs, and to work in the most optimal way with social care providers. In addition, the threshold for admission is low and often occurs out of working hours and weekends. Nearly 50% of those currently admitted are considered delayed discharges. Lack of appropriate step-down options is cited as a common reason for delayed discharge.

The trust reports excessive use of restrictive practices (including seclusion) in inpatient settings. There needs to be a cultural shift away from inpatient care and use of restrictive practices towards community based care and positive risk taking.

Key recommendations

- Develop a **national service model for people with learning disabilities**, which could be informed by the NHS England (2015) national model.
- Develop **robust and responsive multi-disciplinary community services** to mitigate reliance on inpatient services.
- Develop **joint strategic health and social care commissioning policy** for people with learning disabilities to ensure the right community services are available

- **Increase the accountability of providers** supporting people with a learning disability with complex behaviours
- **Specialist admissions due to complex / challenging behaviours should be a last resort** and only agreed by an admissions panel.
- **Enable access to mainstream service provisions,** such as crisis teams or inpatient services if risks warrant this.
- Review **the Mental Health Order (1986) code of practice:** national guidance on the appropriate use of seclusion and segregation as well as involving specialists in learning disability in Mental Health Order assessments.
- To adopt a **systematic approach to reducing restrictive practices**. This could focus on improving training and development, clinical governance and policies, and explicit use of quality improvement methodology.
- To **visit other services to share ideas and see practice in action.** We would be happy to host such visits.

Date of Report

August 2019

Report Authors

Day Njovana, Niall O'Kane, Mary Marcus, George Chingosho and Ian Hall
for East London NHS Foundation Trust

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Background

Dr Cathy Jack, Medical Director and Deputy Chief Executive of Belfast Health and Social Care Trust, contacted Navina Evans, Chief Executive Officer of East London NHS Foundation Trust in Spring 2019, to ask the Trust for support and advice in tackling problems that had arisen at Muckamore Abbey Hospital.

Muckamore Abbey is an inpatient service for people with learning disability that has developed out of an old long stay mental handicap hospital. It is 30 miles distant from the Belfast Trust's acute sites in Belfast. Some years ago the Bamford review identified that its purpose and focus needed to change, and that lots of patients were being deprived of liberty, and patients needed discharge. There have been major problems with discharge so that of the 64 beds, a large number of people are delayed discharges (in Spring 2019 this was 46%, with 5 on trial leave).

In 2017 there were several incidents of alleged physical abuse between patients and staff. These were identified by CCTV recordings that the staff had been unaware of. Now the staff are aware, there have not been such incidents, and the Trust has some assurance that people are safe by ongoing sampling of a random shift for every inpatient ward every week. There have been a number of temporary suspensions of staff. Staff are demoralised, patients unsettled and families distraught.

The Trust was concerned about possible lack of adherence to the seclusion policy. They identified issues with the culture of the hospital, that the staff don't always appreciate the significance of what has happened and are hurt by media coverage, and were not aware of what was happening.

Remit

We used a process of internal discussions in both organisations, and phone calls and teleconferences between us to identify and agree the remit of an initial phase of the work. Further work may arise out of this initial phase.

In the initial phase we agreed to provide consultation and advice in the following three areas:

1. **Addressing restrictive practices.** This would include reviewing policy and practice in relation to seclusion and physical intervention, including appropriate metrics.
2. **The development of robust community services.** This would include home treatment, crisis services and long term living arrangements. It would also include joint working with adult mental health services.
3. **Provider development.** Aspects to address include training to providers, models of working together, and models of commissioning and governance.

Process

We agreed on three main elements for this initial phase

Sharing of information

We were able to review the following documents

1. Seclusion and restraint/physical interventions policy
2. Organisational Chart/Structure of Inpatient and Community services for people with learning disability
3. Operational policies for Inpatient and Community services
4. Anonymised case studies to illustrate the challenges being posed
5. Data on restrictive practices (seclusions, restraint, observations and Rapid tranquilisation)
6. Information about the SITREP and PIPA meetings in relation to restrictive practices)

Visit to Muckamore and Community Services

Five people made up the ELFT visiting team

- Dr Ian Hall, Consultant Psychiatrist for people with learning disability and Clinical Lead
- Day Njovana, Head of Forensic Nursing and Associate Clinical Director of Safety and Security
- Mary Marcus, Service Manager, Tower Hamlets Community Learning Disability Service
- George Chingosho, Clinical Nurse Manager, Shoreditch Ward
- Dr Niall O'Kane, Consultant Psychiatrist, Islington Learning Disability Partnership

We visited on 26-28 June 2019. During the visit we were able to see both the inpatient and community services and speak to a range of stakeholders including people with learning disability. We saw

- The various ward environments at Muckamore, including facilities for seclusion and segregation
- Ward team meetings
- Multidisciplinary inpatient teams
- The lead for implementing Positive Behavioural support
- Attended a restrictive Practice workshop
- Examples of community services, both where people live and day services
- A Community Learning Disability team
- Consultant Psychiatrists working in the Learning Disability services.

Unfortunately during this short visit we did not have the opportunity to meet with families, or with people working in mainstream mental health services, or see MAPA training in action

Initial Report

We gave a face to face feedback summary of preliminary findings on the 28th of June to the trust. This initial report summarises our findings and gives our initial advice and recommendations.

Review of Restrictive Practices

Positive and Proactive care: reducing the need for restrictive interventions (Department of Health, 2014) sets out organisational guidance framework to be used in reducing restrictive interventions by providers. Mental Health legislation (*Mental Health Act* (1983, England and Wales), and the associated *Mental Health Act Code of Practice* (2015)) expects providers who treat people who are liable to present with behavioural disturbances to focus primarily on providing a positive and therapeutic culture. We used these frameworks to conduct our review of inpatient restrictive practices at Muckamore Abbey Hospital.

Good practice

On our visit and discussions with staff, we found the staff to be caring, knowledgeable and showed a willingness to improve patients' experience of the service. We were taken aback by the openness and honesty of staff in their experience of working with restrictions. Staff we spoke to were complimentary of the service initiatives to reduce restrictions. We were able to observe a lot of good practice in relation to restrictions such as the environment being personalised for patients, good adaptations being made to accommodate risk and needs as well as the trends towards a reduction in restraints across the service. We were particularly impressed with the feedback we got about the children's service implementation of the Positive Behaviour Support approach (PBS) and a reduction to no seclusion for the last few months.

We were able to review the Belfast Trust's restrictive practice policy prior to our visit to the Trust. There is evidence that the services at Muckamore Abbey hospital are working within the stated policy. The service uses the SITREP meetings to review restrictive practices on a weekly basis to enable learning and sharing of knowledge across the system. We were encouraged by some outstanding understanding of patients need and the ability of staff to be creative when dealing with challenging situations.

Methodology

We visited the wards Cranfield 1, Cranfield 2, Cranfield ICU and Six Mile, and completed interviews with staff, reviewed patient documentation, reviewed all the reports into safeguarding, restraints, seclusions, seclusion policy for the service and other detailed documents that were sent prior to our visit. We were also able to participate in a workshop on restrictive practices which was run by the service and discuss likely approaches to reducing and accounting for restrictive practices in the service.

As part of this review we specifically looked at restrictive practices in the areas below which we will expand on, highlight good practice and offer suggestions for improving the current practice.

- Seclusion
- Segregation
- Enhanced Observations
- Positive Behaviour Support Plans

Seclusion

Prior to the visit we were sent the *Policy and Procedure for use of seclusion in adult learning disability inpatient settings*, which was reviewed earlier this year as part of the ongoing work to improve this practice at the Belfast Trust. As part of our review, we visited the hospital's seclusion facility which is located on Cranfield Intensive Care Unit. This facility is up to date and in line with the England and Wales *Mental Health Act Code of Practice* (2015). The seclusion suite offers dignity, privacy and space to support destabilised service users which is absent of blind spots and has clear observation areas.

The seclusion practice as described by staff was in line with the *Northern Ireland Mental Health Order* (1986) which gives brief details on standards of seclusion practices. We heard that seclusion is initiated by qualified practitioners and that it is used for the shortest time possible. Staff told us that there had been a reduction in seclusion use across the service over the past year and that seclusion was reviewed in line with the revised policy. Some staff said they had not sighted the updated seclusion policy and were unfamiliar with the changes.

We were told that the unregistered staff complete seclusion observations but did not have access to the electronic health records of patients. It was a frustration for them that they had to handover their information to others for this to be put in the patient's health records. We observed that seclusion observations were recorded on a paper file which makes it difficult to transfer the information into the electronic patient records.

We received and reviewed data in relation to trends of seclusion and noticed that the seclusion numbers remain steady through the period May 2018 to April 2019. In our discussions with staff and review of the data on seclusion we noticed that seclusion episodes were being instigated in different rooms which are not the official seclusion room for the service. Across the service, a handful of patients accounted for most of the seclusion episodes which we understood occurred in patients' bedrooms. Though not covered in the Northern Ireland *Mental Health Order* (1986), the England and Wales *Mental Health Act Code of Practice* (2015) in relation to seclusion supports the use of specifically designated rooms that serve no other purpose or function for the ward but seclusion.

Staff told us that the service follows the local seclusion policy in such instances. When we reviewed these rooms used for seclusions, we were not assured that these rooms should be used to seclude patients. This was because of the poor visibility that these rooms afford, as well as compromising patients' dignity as staff have to go into the room to support patients when they use the bathroom facilities which are locked during a seclusion episode.

Seclusions episodes are usually reviewed by the staff on the ward with help at times from other members of the Rapid Response Team. Staff agreed that it might be helpful to have a senior independent nurse who could help the teams think of different ways of supporting seclusion and enhance the governance and curiosity around terminations or initiations of seclusion episodes.

In relation to data and trends for seclusions, we were impressed with level of detail provided for seclusion episodes in the PIPA meetings, SITREP meetings, and Incidents,

Safeguarding and Use of Physical Intervention and Seclusion reports which we reviewed prior to the visit. Notwithstanding the good level of details of the above reports, we noticed that the teams on the wards were not sure of their data, trends and learning in relation to seclusion practices. Some staff were not aware of the SITREP meetings and how this was part of the local ward governance processes. We are conscious that all wards mentioned the use of PIPA meetings to review seclusions and other restrictive practices, some staff reported that due to the level of activity on the wards, the meetings are usually attended by senior staff hence reducing the effectiveness and shared ownership of these meetings and interventions discussed thereof.

Seclusion policy

Our review of the seclusion policy raised a few issues that needed addressing and consideration by the hospital management team. We have sent back specific comments already as we were mindful that the policy is in pilot phase. Below is a summary of the areas that we have said might benefit from strengthening or reviewing in the policy.

1. Secluding patients in own bedrooms: are these bedrooms designed for seclusion or does the process need to be thought of differently –for example as segregation
2. Voluntary confinement: will this term cause confusion, and does it represent segregation?
3. Authorisation and Termination of seclusion: interpretation of this by the staff? See ELFT *Seclusion Policy* (2018) for Guidance on Initiation and termination of seclusions
4. Detaining patients under the Mental Health Order (1986) if they needed seclusion: This section needs more explanation about who does what.
5. Use of disposable hospital gown: this could raise concerns about patient dignity – do you need something robust that offers more dignity and reduces the ligature risks? We are happy to share our suppliers of these
6. Review processes need to be simplified if possible: see ELFT *Seclusion Policy* (2018) guidance for nurses and doctors. Note that this guidance is in line with the *Mental Health Act 1983 Code of practice* (2015)
7. Reviews at night for sleeping patients: we would suggest these are simplified – See ELFT *Seclusion Policy* (2018) for guidance reviewing sleeping patients
8. Recording of seclusion episode in PARIS: can the record be embedded in PARIS rather than on paper notes – See ELFT *Seclusion Policy* (2018) for Guidance on recording of seclusion
9. Staff training for seclusion / restrictive practices – This is not mentioned but will help if seclusion training is mandatory for all staff that do observations
10. Policy Launch: this might be helped if the policy is reviewed and discussed with all ward/ MDT teams prior to finalisation.

Further to the above comments on the policy review notes, we also make further suggestions in the *Service Approach to Restrictive Practices* section of this report below.

Enhanced Observations

A commonly employed definition of observation of patients states that observation ought to be seen as a partnership between the multi- disciplinary team and the patient and their carers. It should not be delivered in a way that is, or is perceived as, custodial or punitive. As

a general principle the level of supportive observation should be set at the least restrictive level, for the least amount of time in the least restrictive setting possible

On our visits to the wards, we were told by staff that observations are prescribed by the RMO and that these were reviewed in the PIPA meetings. We were struck by the number of patients that needed 1:1 or 2:1 observations across the service. We acknowledge that enhanced observations are not covered by the *Northern Ireland Mental Health Order* (1986), although they are covered by the *Mental Health Act 1983 Code of Practice* (2015) so consideration of the guidance in the Code might be helpful in supporting changes to practice.

The understanding of patients' need by staff on the wards was impressive, in particular in relation to triggers and responses to distress. We noted that most staff we spoke to about enhanced observations practice wanted this to be the least restrictive possible to meet the patients' needs. Some staff felt that observations were not thought of as restrictions and that if the parameters for observations were reviewed this could lead to lesser restrictions and better utilisation of the resources in across the service.

In our discussions with staff, there was a sense that the number of safeguarding incidents that are raised across the service was correlated with the level of observations. Notwithstanding this, the staff felt the observations were appropriate in most situations. In terms of how observations impacted on their work, the staff suggested that observations were the biggest single use of resources on their wards and that the staff felt the reviewing systems could be improved.

On most wards, staffs were unable to tell us of the formal processes by which observations were reviewed and terminated. We had been told that this is done in the PIPA meetings on a daily basis and that these are prescribed by the RMO. We were told that some service users have been on 1:1 or 2:1 observations from admission and that this was the practice on most wards. It seems that most of the staffing resources on the wards were spend on 1:1 or 2:1 observations. In the review of patient notes, we found little evidence of observations being reviewed consistently and alternatives being offered.

Observations should be seen as part of restrictive practices. It will be helpful if the management of the hospital review observations practice in the service as part of the ongoing review into reducing restrictive practices.

Segregation/Special Accommodation for Dangerous patients

We noticed that the trust has no formal process for the use of segregation. The *Mental Health Order* (1986) expects that some patients who demonstrate behaviours that are deemed dangerous but not meeting the threshold for high security can be supported with special accommodation. In our view, though not specifically mentioning it, the Order supports use of segregation in line with the *Mental Health Act (1983) Code of Practice* (2015).

It would be helpful for the trust to consider instituting a Segregation Policy as some of the described approaches can be seen as Segregation from a Mental Health Act Code of Practice perspective. For example on some of the wards patients could not freely move across the ward and had designated areas where they were allowed to use (described as 'Pods'). We note that such practices would need robust governance and other considerations such as training in Mental Capacity legislation and Deprivation of Liberty safeguards (in relation to the new Northern Ireland legislation) for the service for this to work.

We were pleased to see the provision of person centred accommodation that is driven by need and risk management and we would urge the service to devise a formal way in which these are agreed and decided with the patients, relatives and service management. We are eager to say that most staff we spoke to were clear on the rationale for use of these segregated accommodations.

Additional service wide approaches to segregation and suggestions for development are noted in the Service Approach to Restrictive Practices section below.

Positive Behaviour Support Plans and Physical interventions

Good practice

In terms of PBS, we were pleased to note that this has now become the focus of the service in understanding and supporting service users with challenging needs. Our understanding of the model in use at Muckamore, and experiences reported to us, suggested that staff were aware of this approach but also that there was variability in engagement in this approach across teams in the service.

We saw some really wonderful work on our visits to the ward which was directed by the PBS plans. Staff we spoke to were able to identify triggers and rationale for PBS and how this had changed and enhanced their understanding of their practice with a number of service users that had PBS plans in place. The documents for PBS reviewed showed a level of creativity and flexibility to allow for the service users to be supported in the least restrictive environment.

Areas for development

We were informed that they were some PBS support workers that were aligned to the wards and would support in developing PBS plans although recently due to service needs they had been focusing on community work. Other ward teams suggested that the PBS support workers were at times were unable to support the formulation of the PBS plans as they were unable to record their notes on PARIS as well and not ordinarily involved in reviews or PIPA meetings.

Training for PBS was variable between different teams and staff in the hospital. Some staff said they had a good understanding of the PBS concepts and had training outside of that provided online, others suggested that they had only completed some online training and were not fully aware of the concepts of PBS.

Suggestions for taking things forward

It might be helpful for the service to consider PBS from a team based quality improvement perspective, to include training of teams to support the integration of the PBS ways of working into their ordinary practice. We are currently in the process of doing this in our inpatient forensic services at ELFT. There is however limited literature that evaluates its efficacy in adults with ASD and Learning Disabilities further complicated by aggressive and offending behaviours.

In our experience, the challenges that a combination of complex psychiatric morbidities and offending behaviours present for multidisciplinary teams across services cannot be underestimated. Such is the complexity that we have needed to respond in a way that not only meets the needs of service users but also deals with and addresses the human responses evoked within clinicians that work in such services. We have found that adopting a quality improvement approach to PBS enables us to unpick and address this.

Several versions of positive behaviour support have been trialled within our service with mixed success, and we have used a quality improvement approach to work out the best approach. Given that the underpinning theoretical framework for positive behaviour support has its roots in psychology traditionally positive behaviour support plans have been held within the psychology department. However we have noticed however that whilst it is invaluable to have an enthusiastic, passionate and knowledgeable practitioner leading the PBS, this alone does not go far enough in Influencing a culture of positive behaviour support on a ward.

A key barrier to successful implementation of positive behaviour support is poor 'buy in' from the team, especially unregistered staff who in reality spend the majority of their working day in direct contact with service users. This can mean using well meaning evidence-based approaches without the full team support have not been successful.

Nursing managers have a crucial role to play in order to improve "buy in" from staff. We have therefore found it crucial that nursing managers have sufficient knowledge and understanding of the principles of positive behaviour support. It is also important that nursing managers fully subscribe to this way of working before they can commit to "selling" it to the rest of their team.

One reason we advocate for this in our service is that Nursing managers and Matrons are involved in recruitment, induction, and supervision of all new starters for at least the first 6 months of them starting their role. This gives nursing managers more opportunities for modelling and coaching new starters in this way of working. We have observed how this increases the chances of positive behaviour support becoming embedded in day-to-day practice.

Nursing managers can also lead on modelling the application of techniques with complex presentations. Typically this involves taking on the challenge of implementing or trying out a technique that has been agreed upon by the team especially when some positive risk-taking is involved. Their experience of applying such a technique of a short period of time is then reflected upon and discussed with the rest of the team. This may involve some modification

of aspects of the technique before it can be rolled out. This way of working allows for the development of team cohesiveness and a sense of togetherness. It also promotes autonomy by giving people permission to try out new things that can then be shared with the team.

Another important aspect of implementing PBS across a team is the availability of support. It is therefore important that whatever approach they are expected to implement demonstrates good practical clinical utility. Regular discussions about people's experiences in applying techniques to a problem must be prioritised. A daily or as needed platform for this can be useful in trailing techniques and questions can be answered about people's anxieties and frustrations and responded in the moment. In our experience this increases people's confidence and commitment to this work.

Training for the entire team in the principles of positive behaviour support is also essential. This approach offers shared ownership and empowers clinicians and improves commitment to the shared mission.

Another important aspect is taking a team approach to understanding and making sense of service user behaviours and their presentation. In practice for us this means dedicating time during our team away days or safety huddles to describe and discuss observed settled / baseline behaviours and engagements that keep service users at baseline (with a view to increasing or enhancing such engagements). This also involves noticing subtle cues such as physical appearance, demeanour, routines and body language and dress just to mention a few.

Each member of staff that has direct contact with the particular service user being discussed regardless of their discipline or banding is welcome to contribute to this process. The same is repeated for observed triggers and signs of escalation. Service user input and views of families / carers and previous care providers are also sought during this process. Strategies to bring people to baseline are also explored during this process. In our team the process of formulation is usually led by the ward psychologist who helps and guides the team to make sense of information gathered by staff about a service user. A team approach also helps identify those who are struggling with the concept and allows for them to be supported.

Additional service wide approaches to PBS and suggestions are noted in the *Service Approach to Restrictive Practices* section below.

Service Approach to Restrictive Practices

We recognise that the service is working hard to establish processes and governance for restrictive practices as mentioned above and that SITREP and PIPA forums are in place. Overall we would encourage the service to establish a governance system that picks up, reviews and makes sense of restrictive practices that is owned and governed locally by the ward clinical teams, in addition to the service wide meetings (SITREP). This should help to support the reduction, rationale and consistency of restrictive practices in everyday work.

The safe and therapeutic care in services for people with mental health, intellectual and developmental disabilities, some of whom will on occasion put their own safety and that of

others at risk, is a multi -faceted challenge in terms of adherence to legal, ethical and government guidance and professional conduct codes. Where the restriction of people's liberty and choice is supported by such frameworks it is essential that the culture of professional care enables a Recovery focus, and incorporates positive risk taking.

NHS England set out a CQUIN target and framework for reducing restrictions for all Medium and Low Secure Services across England from April 2016 to April 2019 (NHS England, 2016). This formed the basis of the reducing restrictions work plans for all providers in England. ELFT has used this framework to enhance the reduction programme and embed a culture of questioning restrictions as set out in the services. The programme's aim is to ensure that we improve patients experience whilst maintaining safety**.**

As part of the reducing restrictive practice work, we would strongly recommend establishing a steering group within Muckamore Abbey Hospital with specific remit to make key decisions and support the work streams of clinical, service improvement and involvement teams (service user groups) dedicated to the identification, challenge and continuous reduction of restrictive practices. The group should also have links to wider work in the organisation dedicated to restrictive practices that is sponsored at Executive Director Level.

One approach we have found very helpful in reducing restrictive practices is to task the wards to review all restrictive practices with patients on their ward through the lens of a 'working day'. This will allow wards and the service to identify restrictive practices embedded which might vary from ward to ward. The process can help in supporting staff on the floor to take ownership of and understanding the rationale involved in initiating and reviewing restrictive practice, including patient involvement and ways to reduce these practices. It can also support the strategies to tackling restrictions such as Quality Improvement projects, review of policies, and staff training on restrictive practices.

The service can also identify performance measures which can be further developed over time to determine the effectiveness of the service restrictive practice reduction plan and which can measure key outcomes for patients such as number of seclusion, restraints, rapid tranquilisation, prone restraints, debriefs and learning from all the incidents when restrictive practices have been applied.

The guiding principles for our work on restrictive practices has been trusting that frontline staff are well trained enough and understand the most about what they have observed; they can also be trusted to act, take decisions and lead in real time (accepting it can go wrong too, but still backing them). We find that it is the best, most efficient and quickest way to act on information. Also while we set objectives, we give freedom to each individual in how they will be achieved.

It is helpful for the service to consider a systematic approach to reducing restrictive practices. In recent years, East London Foundation Trust have focused on improving training and development, clinical governance and policies, as well as using quality improvement methodology. Specific examples of what we have found helpful and what the Belfast Trust could consider are listed below.

Training and Development

- Introduction of away days for all wards
- Mental Capacity and DOLS training and understanding
- Service wide restrictive practices events to share learning
- Restrictive Practice training as part of all new staff induction
- Publicise restrictive practices to patients and staff
- Training for seclusion for all staff who complete seclusion observations as part of their induction into the service
- Specific work to be targeted to the small number of patients that raise the most number of seclusions in the service.
- Team training to PBS
- Specific LD training for all staff in away days i.e TEACH, ASD training, sensory integration training

Governance

- A Service Restrictive Practice Forum (Safe and Positive) that considers all restrictions (See *Safe and Positive Restrictive Practices Workgroup* (East London NHS Foundation Trust, 2019b) Terms of Reference and Agenda)
- Review of impact of safeguarding processes on increasing restrictions
- Introduction of a Duty Senior Nurse with training to include daily reports on incidents and restrictive practices used in the preceding 24hrs. We would be happy to share our ELFT DSN report format (see *Duty Nurse Induction* (East London NHS Foundation Trust, 2019a))
- Introduction of restrictive practices registers for each ward as a base line measure and audit tool
- Introduction of Ward Clinical Governance structures (also called Clinical Improvement Groups) to embed Restrictive Practices improvement work (*Ward Clinical Governance – Terms of Reference and Agenda* (East London NHS Foundation Trust, 2019c)
- Conducting peer reviews across the service and devised action plans specific to Wards

Quality Improvement

- Quality improvement initiatives to tackle restrictive practices such as Flip the triangle, National collaborative on restrictive reductions across mental health wards and reducing restrictive practices in a low secure learning disability ward as cited below (please ask us if we can give you a login if you would like to access these).
  https://uk.lifeqisystem.com/projects/120196/general/
  https://uk.lifeqisystem.com/projects/114547/general/
  https://uk.lifeqisystem.com/projects/118921/general/

Policy development

- Joining National Projects or Networks on Reducing restrictive practices
- Develop Segregation Policy for the service
- Review of Observation Policy
- Review Seclusion Policy

Other Recommendations

- ELFT co-working with Belfast Trust and sharing ideas to reduce restrictions. For example thought visiting our service and seeing the practice in action
- Sharing Policies and Procedures as well as meeting formats that support governance of restrictive practices

Community Services

We visited a range of community provisions for people with learning disabilities, including:

- Cherry Hill, Muckamore - newly commissioned bespoke community stepdown for long-stay patients at Muckamore Abbey Hospital (Houses at the edge of the hospital site with single tenants and joint staff team),
- Everton Day Centre (Belfast Trust day centre for people with learning disability)
- Hanna Street Residential Unit (Belfast Trust directly provided residential unit)
- West Belfast multidisciplinary community learning disability team

We spoke to a range of professionals working with people with learning disability including occupational therapists, psychologists, social workers, support workers, psychiatrists. Importantly, we had the opportunity to meet with and speak to people with learning disabilities using directly provided (in house) services. Finally, we attended a workshop/focus group session on the development of robust community services, which provided an opportunity to share experiences of good practice and discuss different service models, including those used in England.

Good practice

We found many areas of good practice in the community settings. We met staff who were very compassionate, highly motivated and clearly enjoyed their work. Staff wanted to improve and develop community services and recognised the recent events at Muckamore Hospital as a critical opportunity to get things right for the future.

The staff at the day centre and residential services embraced person-centred values and were very proud of those who they supported. The day centre and residential services appeared to be very well led and managed. As the trust oversees these services, this ensures greater accountability and oversight of learning disability service provisions. Of particular commendation was the use of co-design and co-production to improve quality at the day services.

People with a learning disability accessing the in-house day services receive a wide range of meaningful activities. They are empowered to participate in new activities and training programmes, including delivering choking awareness and epilepsy awareness training to healthcare professionals. At the residential unit, we spoke to residents, all of whom told us that they enjoyed living at Hanna Street.

The West Belfast Community learning disability team was a fully integrated health and social care service and was well staffed. Their multidisciplinary team (MDT) included: Speech and Language Therapists, Occupational Therapists, Physiotherapists, Psychologist, Nurses, Psychiatrists and Social Workers. We learned about the community LD team investing in innovative service models such as the development of a behavioural specialist support team as a way of mitigating admissions to hospitals by enhancing crisis support for providers out of hours.

What to develop

At the time of writing, we understood that the Belfast Trust was taking active steps to address the areas discussed below. Notwithstanding this, we thought it important to emphasise these areas of development, especially when considering service provisions for people with learning disability across the whole of Northern Ireland.

Accountability and empowerment of providers

We heard that many people with a learning disability were admitted to specialist inpatient beds outside of normal working hours or at weekends. Everyone we spoke to agreed that this needs to stop happening. The community team highlighted many reasons why emergency admissions happen. Placement breakdown was considered as one of the main reasons with the provider having a low threshold to bring a person to Accident and Emergency rather than seeking support via community services. Historically, support providers may have been less likely to contact the community teams early on to mitigate crises and to think about how to manage before a crisis situation escalates.

There is a need to develop and empower greater positive risk taking culture amongst providers and different services working with people who have complex behaviours. Accountability and quality assurance of providers is needed. This can be achieved by closer liaison and contract monitoring of providers by commissioners and community teams. It might also be helpful to relook at prioritisation of workload in the community teams to make sure that providers can get support straight away in a crisis.

Crisis management and avoiding hospital admissions

Admissions to hospitals can be very traumatic for people with a learning disability. Admissions should only be considered if there is clear evidence of a severe mental disorder and appropriate assessment and/or treatment is available. There is growing evidence to suggest that admitting people with a learning disability who display challenging behaviour in the absence of a serious mental illness can lead to an increase in challenging behaviour (NICE Guidelines NG11, 2015). Furthermore, people with a learning disability admitted to specialist behavioural units (Assessment and Treatment Units - ATUs) have more than double the mean length of stay compared to being admitted to generic or mainstream units (Saeed H., et al (2003) and Xeniditis K., et al (2004)).

The threshold for detention of a person with a learning disability under the Mental Health (Northern Ireland) Order (1986) is low. The detention process is led by General Practitioners (GPs) and Approved Social Workers (ASWs). We learned that GPs and ASWs may not have the expertise in the assessment and management of behavioural issues in learning disability including awareness of alternatives to admission to hospital. We would recommend a review of local MHO policies to highlight the need to involve staff who are suitably qualified or have expertise in learning disability in MHO assessments. A model for this is provided in the English Mental Health Act 1983: Code of Practice Chapter 20 (People with learning disabilities or Autistic Spectrum Disorders) (Department of Health, 2015).

Where an admission to a specialist hospital is needed and in the person's best interest, we would recommend that these admissions are only agreed via an admission panel and emergency/direct admissions to specialist hospitals should not be permitted. Where a person with a learning disability is experiencing a relapse in their mental health, LD

community teams should of course prioritise the case, but also consider co-working with mainstream adult mental health provisions including using their gateway pathways (crisis teams, home treatment teams, or admission to mainstream mental health units). This is discussed in more detail below.

Focussing care on those with greatest needs and complexities

Community teams have large caseloads. Large caseloads mean it can be challenging to focus care on those with the greatest needs. Psychiatrists we spoke to said that a significant contributing factor to large caseloads is the lack of local agreements to discharge people back to primary care. For example, there are no current agreed policies on discharging people to primary care who are stable on long term antipsychotic medication, and no longer needing psychiatric intervention. We would recommend that GPs are supported to take over care of these individuals. In turn, this would help community LD teams focus on complex cases as well as freeing up clinician time to focus on other important areas, such as learning disability training, policy development, liaison work, co-working and building relationships with mainstream mental health services.

Recommendations

Community teams need to robustly challenge care and rationale for inpatient stay in hospital and facilitate discharge

An initiative developed by the Department of Health in England as part of reducing dependence on admission to hospital and facilitate faster discharges is the Care and Treatment Review (CTR). The panel consist of an independent expert clinician, an expert by experience (often a carer or parent of a person with a learning disability), and is led by the local LD health commissioner. See *Care and Treatment Reviews (CTRs): Policy and Guidance* (NHS England, 2017) for more information on how these meetings can be arranged, led and implemented.

These meetings can be used both when admission to a specialist hospital is being considered, and can be very effective in thinking about and getting sign up to alternatives to admission. They are also used to facilitate discharge from hospital, again by bringing an external perspective to thinking about community support, and ensuring resources are forthcoming.

Implement risk of admission registers, flag up risks with commissions including complex case review systems

Those who may be at risk of admission should be flagged up within community LD services and added to a 'RAG' rated at-risk register (see NHS England, 2017). In England, these risk registers are the responsibility of the health commissioners but usually delegated to community learning disability teams to maintain. The risk register should be reviewed at least weekly both by the multidisciplinary community learning disability team and learning disability commissioners. Those at high risk of admission can then be considered for a CTR, involving commissioners, experts by experience and independent clinicians.

Those who have complex needs and risks associated with their presentations can benefit from regular multidisciplinary input and discussion. Therefore, establishing weekly complex

case risk discussion at community learning disability team meetings can be helpful especially for enhancing responsiveness, enabling early intervention and accessing more resources. Discussions should also involve providers and families as appropriate.

Invest in co-working and improving relationships with mainstream services

Community Learning Disability teams should consider working jointly with mainstream services (Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability, 2013;. NHS England, October 2015b). Such working is described in detail in the Royal College of Psychiatrists report *Enabling people with mild intellectual disability and mental health problems to access healthcare services* (2012).

Examples of such working are given in the *Winterbourne View Review Good Practice Examples* (Department of Health, 2012, see page 54 for Tower Hamlets example), and an example protocol that we use in East London Foundation Trust (ELFT) (*Working together in Adult Mental Health and Learning Disabilities Services in East London*). This is primarily for people with a mild to moderate learning disability experiencing the onset of a mental illness, or a relapse.

This working together should include access to crisis teams to help prevent admissions. If an admission is needed (for example, due to severity of the relapse and associated risks), then admission to mainstream mental health units should be considered. For this model to work effectively, community LD teams need to proactively co-work with inpatient teams, and prioritise such cases. For example, the community psychiatrist, community learning disability clinicians and social workers should be flexible in order can attend ward rounds, and support the inpatient team in making reasonable adjustments and developing their skills in supporting people with a learning disability, as well as actively planning the discharge from the outset. We learned that the BSCHT mainstream mental health units utilise a structured discharge planning model at point of admission, known as Purposeful Inpatient Admission (PIPA), which has been shown to reduce the length of stay in hospital, and which would seem to provide a good structure for the Community LD services to proactively participate in.

Continuous professional development and share good practice

We have found it highly beneficial to share good practice and learn from other learning disability health and social care teams. To share learning and good practice we would be very please to welcome BSHCT learning disability services to visit LD services in London. Additionally, we would emphasise the importance of each trust developing regular regional/cross trust MDT training, learning and development programmes.

Improve relationships with commissioners and understanding local population needs

Building good relationships with those who commission learning disability services ensures better, more person centred services. In turn, this leads to improved health outcomes and reduction in unnecessary admissions to hospitals. It is important that commissioners are well informed about the needs of people with a learning disability, by working in partnership with the community LD services, service users, and families. Therefore, we recommend developing a joint health and social care commissioning strategy tailored to local population needs. Good strategic commissioning can help people be healthier, more connected and more in control. There have been a number of reports detailing on what

good commissioning should look like for people with a learning disability. These reports are listed in the reference section with the relevant links (NHS England, October 2015a; Joint Commissioning Panel for Mental Health, 2013; Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists, 2007; and Royal College of Psychiatrists & British Psychological Society, 2016).

During our visit to it was very evident that community services are keen to develop further local community options from other providers. The Belfast Health and Social Care Trust seem to have some delegated commissioning responsibilities, which means they not only commission some local services but are also then involved in directly supporting these services as a community specialist service to deliver a quality service. The commissioning and provider relationships in England are very separate with clear boundaries and roles and responsibilities to hold local services to account through a framework. Further details of how local services are commissioned were requested by the Belfast Trust and this is certainly an area we can provide further information from links with our local commissioners, in addition to the national documents cited above.

Develop learning disability liaison services

A recent *Confidential inquiry into the premature deaths of people with a learning disability* (Heslop et al, 2013) recommended that all hospitals should have learning disability liaison nurses in acute settings. These nurses can provide necessary links between acute services, community services and providers, as well as a critical role in advocating for a person with learning disability and ensuring reasonable adjustments are being met. This can go a long way to preventing challenging behaviour in acute settings. Learning disability liaison nurses may also provide a pivotal role in MHO assessments, especially where the GP and ASW may lack appropriate expertise.

Improving quality of care by measuring meaningful outcomes for people with a learning disability

High quality care is a high priority for all health services, not just learning disability services. In Northern Ireland, health services are regulated by RQIA. We would recommend implementing national quality standards specific to learning disability (Commissioning for Quality and Innovation, CQUINS) and developing local key performance indications (KPIs). CQUINs and KPIs are systems that make a proportion of health providers income conditional on meeting a set of standards and can help ensuring quality of care. Different outcome measures should be used by both inpatient and community provisions. In England, many services have incorporated the Friends and Family test which can be made accessible for those with learning disabilities (NHS England, March 2015). Involving people with a learning disability in inspection processes is currently being trialled in England. This is known as the NHS England Learning Disability Quality Checker programme. Further details of the Quality Checker programme can be found in the *Friends and Family Test* guidance (NHS England, March 2015)

Develop a National LD Service Model

The recent Winterbourne abuse scandal in England identified the need to have a national, joined up approached to care in order to reduce reliance on inpatient settings and protracted hospital stays. We would strongly recommend the development of a national service model in Northern Ireland. The national model in England is call *Building the Right*

Support (NHS England October 2015b). It was developed with the help of people with lived experience, clinicians, providers and commissioners. It is a person centred and holistic model, and in our opinion is appropriate for all people with learning disability. Implementation of the model, by fully addressing people's needs in the first place, can go a long way to preventing challenging behaviour and mental health problems developing.

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Additional resources

https://www.england.nhs.uk/learning-disabilities/projects/
https://www.england.nhs.uk/publication/nhs-quality-checkers-toolkits/

FFT helpdesk contactable via: england.friendsandfamilytest@nhs.net for access to easy read friends and family test
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19.002

ID & AMH Regional Inter-Trust Meeting

Friday 07th June 2019 at 9.30 am
Boardroom, Muckamore Abbey Hospital

Minutes

Attendees:

Cathy Jack: Deputy Chief Executive, Belfast Trust (Chair)
Marie Heaney, Belfast Trust
Peter Sloan, Belfast Trust
Colin Milliken, Belfast Trust
Joanna Dougherty, Belfast Trust
Uzma Huda, Northern Trust
Seamus O'Reilly, Northern Trust
Alyson Dunn, Northern Trust
Pauline Cummings, Northern Trust
Carole Wilson, Northern Trust
Barney McNeaney, Southern Trust
Pat McMahon, Southern Trust
Paddy Moynihan, South Eastern Trust
Damien Brannigan, South Eastern Trust
Margaret O'Kane, South Eastern Trust
Heather Hawthorn, South Eastern Trust
Dermot Hughes, Western Trust
Valerie McConnell, HSCB

1.0	**Current Context and Challenges** Dr Jack opened by welcoming colleagues and thanking them for giving their time to attend. Dr Jack provided colleagues with a brief overview of the current situation focusing on the critical issue of hospital capacity and admissions in relation to Muckamore Abbey Hospital. Dr Jack highlighted that this was particularly acute presently given the additional pressure of the ongoing investigation, staffing levels due to sickness and precautionary suspensions and patient profile mix. There are 68 inpatients currently at Muckamore Abbey Hospital, however excluding

	the Regional Forensic Ward, only 4 patients require ongoing assessment and treatment. Dr Jack emphasised that there must be a re-focusing on discharging those patients who no longer require active treatment. These delayed discharges, along with the requirement to provide safe staffing on a day to day basis challenge the ability to admit to the hospital. Dr Jack informed colleagues that RQIA had carried out a further inspection and had raised concerns that, in their view, there had been limited improvement especially in staffing levels. Colleagues were further informed that the Belfast Trust are developing a contingency plan which will include the possibly of closing wards and ECRs. Dr Jack acknowledged that if this happened it would put 68 patients and their families into a crises situation and tasked colleagues with helping to find a workable solution. Mr Brannigan, South Eastern Trust, asked if the staffing issue could be quantified further as the mental health staffing vacancy rate is around 30-35%. Mrs Heaney replied that she believed Belfast to be a much higher rate, but would ask Brenda Creaney/Moira Mannion to provide a breakdown to colleagues. **ACTION: Mrs Heaney** Dr McMahon, Southern Trust, stated that part of the issue is recognising exactly what the patient requires and why a placement is not able to be found or has broken down. He highlighted that Bluestone have put a significant amount of work into the turnover and model of care given and believes that ID would benefit from replicating some of the practices within Adult Mental Health. He suggested that focus be given to the reason the model of care has broken down and deal with the issue right at the beginning. Mr McNeany, Southern Trust, informed colleagues that the Crisis Response Home Treatment Service which operates 9.00am – 1am is preventing admissions and enabling a more rapid discharge. If a crisis house service developed in the community this would significantly reduce the demand on beds when combined with CRHT Service Mrs McConnell acknowledged that increased investment was required and stated that the Department were engaged on how to actively manage to pursue the community structure to ensure it can happen.

	Dr McMahon informed colleagues that the ID unit is part of the site of Bluestone which they find beneficial. Dr Jack enquired if this was a partnership model. Dr McMahon responded that with mild learning difficulties partnership is not as much of an issue, however, individuals presenting with moderate or severe problems require specialist nursing care which the AMH nurses are not trained to deliver. Treatment of patients with moderate or severe ID on general psychiatry ward would not be appropriate. Colleagues from the South Eastern Trust highlighted that the Ombudsman and Coroner have both criticised doctors for perceived failings in situations where a doctor had stepped in to be helpful. This has put some Doctors in the position of referring themselves to the GMC and as employers there is a duty of care not to put staff in that position. Dr McMahon stated that under exceptional circumstances and with agreement, patients with mild ID have been admitted to Bluestone for a short, purposeful admission. Dr McMahon confirmed that medical care is always provided by the ID specialist. Colleagues agreed that although there were some overlapping skills between the two directorates there were still fundamental differences in treatment. These differences are more defined depending on the mental capacity of the patient involved. There was a majority view from the psychiatrists specialising in General Adult Psychiatry that in order to provide inpatient psychiatry care to patients with intellectual disability, an appropriately qualified specialist needed to provide that care. It was agreed that this care would be at full consultant responsibility 'name over the bed' level of care. Dr McMahon reported that this is what happens when patients with intellectual disability are admitted to adult mental health beds in Bluestone. Dr Huda reported that this is also what is happening in Holywell. Dr Huda reported that this care is currently being provided by the Northern trust consultants in ID psychiatry. Colleagues acknowledged that individuals with a learning disability have greater vulnerability and there is a risk that they may be exposed to a higher level of violence, and being taken advantage off etc if placed within a regular AMH ward. Mrs Cummings, Northern Trust, stated that NT are in the process of purchasing properties and looking at 'step down' facilities with very little additional finances. She highlighted that the challenge is that while wanting to focus on maintaining patients within a community context it is impossible for the psychiatrist to be attending to both inpatients and community based patients at the same time. Dr Huda supported this point of view and added her concern that the current situation whereby NHSCT psychiatrists in intellectual disability have been providing inpatient care which has impacted

	on their ability to provide community care and risking the destabilisation of community services. There was a general agreement that patients with mild ID could be admitted to AMH wards, but that appropriate specialist medical care should be available if requested. There was agreement that this should not detract from community services as destabilising these may exacerbate the situation further. There was discussion about whether any consultant resources from MAH could be redeployed to the AMH wards with the consultant time following the patient. Colleagues acknowledged that there are staffing pressures through-out each Trust. Dr Milliken added that although Belfast Trust had recruited locum consultants they have struggled to recruit permanent consultant staff for inpatients. Currently there are 2.5 consultants for 53 patients (excluding Sixmile). Identification of a locum consultant ID psychiatrist to provide this care was discussed. Dr Dougherty and Dr Milliken reported that they had had some difficulty identifying a locum. Dr Moynihan South Eastern Trust, informed colleagues that she had been made aware of an ID consultant from England who is re-locating to Northern Ireland and will be looking for work. She agreed to share his details with Dr Milliken. Dr Milliken further stated that although there are currently only 4 inpatients requiring treatment and assessment the level of multi-disciplinary approach doesn't diminish should the patient be delayed in their discharge. Mr McNeany highlighted that Adult Mental Health are also under pressure in terms of admissions and the availability of beds and occupancy rates have been regularly at 105% or more. **ACTION: Dr Moynihan Dr Millikan** The current situation is that the SEHSCT is the only one of the three Trusts not admitting patients with ID to AMH wards. This is because SEHSCT does not have any ID consultant resource to deploy. There was some discussion about whether SEHSCT could seek to employ either community or inpatient based ID consultants. Dr Moynihan and Mr Brannigan responded that they felt this was worth exploring. Dr McMahon informed colleagues that putting patients with an IQ of 69 or below into a challenging ward would cause stress to that individual, however

	acknowledged the need to look at an interim solution. He further stated that RQIA are not in favour of expanding bed capacity. Mrs McConnell stated that the Commissioner couldn't commit to increasing the capacity until they have done a full assessment of what is required and looked at ways of developing a community infrastructure in all 5 Trusts that will keep people out of hospital. She further informed colleagues that business cases are underway, however this could take 5-10 years. Dr Dougherty highlighted that there were specialist areas for those individuals who had moderate and severe learning difficulties but there is a gap for the patients with mild ID both within both LD and AMH. Colleagues agreed that patients with mild ID should be treated in the place that best meets their needs on a case by case basis, however Dr Jack acknowledged that one of the biggest challenges was that there was no bed capacity in either speciality. Dr Jack further stated that if the planned discharges from Muckamore Abbey Hospital happen in June/July that will help alleviate some of the pressure. Mr McNeany emphasised the need for a robust discharge procedure and an assurance that everything is in place to ensure successful transition for patients into the community particularly as third sector placements were not sufficiently robust. Dr Jack agreed but stated that there also needed to be acceptance that the current model is not working and a clear agreement to what is required in the interim Mrs Cummings shared with colleagues a situation during which she was with a patient who required immediate admission, but she was unable to find a place for them.
2.0	**Provider Issues** Mrs Heaney stated that part of the issue is that there has been a lack of Provider development over the last number of years. Dr Huda agreed that there are Provider issues with a number of discharges delayed due to the Provider feeling they can no longer support the person's needs. Dr Dougherty suggested that part of the problem is that Northern Ireland has a small pool of Providers in comparison to the Mainland and asked if the Commissioner could do something that would help attract more providers. Mrs McConnell confirmed that the Board is considering this issue and are planning to release one of their team to work on the discharges in Muckamore Abbey.

	Dr Jack requested the development of clear chart showing each Trust's planned discharges over the next few months. This chart will be shared with each Trust and should be presented at the Muckamore Abbey Assurance Group. **ACTION: Trust Colleagues** Members further agreed that a Regional Bed Manager would be beneficial who would look after each of the 3 inpatient units. Mrs McConnell agreed to raise this with the Department. **ACTION: Mrs McConnell** Dr Jack agreed to write to the PHA to seek clarification on the escalation plan when there are no beds left throughout the Region. **ACTION: Dr Jack**
3.0	**Admission Criteria** Dr Dougherty shared with colleagues a draft criteria for admission for their consideration. It was agreed that Dr Dougherty would email a draft copy to colleagues which would be returned to her with any suggested amendments within one week (Friday 14th June 2019). **ACTION: Trust colleagues** Dr Dougherty suggested that there are Blue-light meetings before admission and an SEA after admission. Dr McMahon stated that it must be clear that this is not an exclusion criteria. He further highlighted that many times you are not treating the overall disorder or condition, but managing the period of risk.

4.0	**Summary** i. People with mild ID could be safely managed in AMH ii. Care should be overseen by an ID Specialist (Name above the bed) iii. PHA in conjunction with Trusts need to develop a clear escalation plan when no regional bed iv. Regional Bed Manager for all 3 inpatient units needs to be appointed v. 3 Acute inpatient ID units need to develop and agree SOP vi. Admission Criteria to be redrafted following feedback and then shared with all ID Teams (Joanne Dougherty) Dr Jack thanked individuals for attending and agreed further meeting over the summer when the Trust had been able to review the admission criteria.

Reference No:

Title:	Adult Learning Disability Services Admission and Discharge Policy		
Author(s)			
Ownership:	Insert name of Director / Service Area / Group / Directorate		
Approval by:	Insert name of Trust Committee / Group responsible for approval	Approval date:	Insert date each committee approved
Operational Date:	2019	Next Review:	2024
Version No.	1.0.1	Supercedes	V1.0
Key words:	Intellectual		
Links to other policies	Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010; Belfast Health and Social Care Trust Self Discharge Contrary to Medical Advice (CTMA).		

Version control for drafts: (This box to be removed prior to issue).
This helps to identify where changes have been made to a document and ensure that authors / reviewers are using the most recent version.

- The first draft will be versioned as 0.1 with subsequent versions 0.2, 0.3 etc. When formally approved it will be issued as 1.0.
- Reviews will then be versioned 1.0.2, 1.0.3. Following second formal review the document will be issued as version 1.1
- If major changes are made to the document then it will be issued as version 2.0.

Date	Version	Author	Comments
15/10/14	0.1	J. Armstrong P. Minnis	Policy amended
05/03/2015	0.1	As above	Approved by LD Governance

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This policy has been developed to supersede any previous admission and discharge policies and to ensure a standardised approach to admission and discharge within relevant wards in Muckamore Abbey Hospital

1.2 Purpose

To ensure that the admission to and discharge from an inpatient ward is viewed as a single process that enables staff to provide structured and continous care - discharge planning will start at the point of admission.

1.3 Objectives

To provide a purposeful, effective and safe experience to the patient during their admission to and discharge from hospital.

2.0 SCOPE OF THE POLICY

This policy applies to all patients, voluntary and detained, admitted to and discharged from admission wards in Muckamore Abbey Hospital.

3.0 ROLES/RESPONSIBILITIES

All staff working within a learning disability hospital or involved with the patient in the community have a responsible role to play in achieving the policy objectives.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

Admissions will only be considered appropriate when the admission criteria has been met.

4.2 Key Policy Statement(s)

Patients are identified by their community teams as being at risk of admission. It is expected that all avenues of treatment and care will be demonstratively exhausted before an admission to hospital is negotiated. Aims of admission will be clearly stated to the admitting team.

The process will be respectful of the individuals human rights.

Patients/next of kin/ and or their carers will will be involved in all decisions recarding their care and treatment.

Tthe experience of the patient and their next of kin/ carer during the admission and through to discharge will be one that is positive, seamless, respectful, compassionate, inclusive and meaningful.

4.3 Policy Principles

4.3 Admission

Patient can be admitted to a learning disability hospital in 2 ways.

- Voluntary
- Detained under the Mental Health Order (NI) Order 1986

4.3.2 On Admission

- Where possible relevant information will be provided on or peior to admission.
- In cases where the patient has been escorted by the PSNI or ambulance, the admitting nurse will immediately seek and record all relevant information from them.
- If the patient has been brought to hospital by a community practitioner a risk assessment tool in keeping with Promoting Quality Care – Guidance on the Assessment and Management of Risk, DHSSPS, May 2010 should be available, if not a risk screening tool will be completed
- Detention forms will be checked by nursing staff for their accuracy.
- Patient and their carers will receive any documentation, relevant to their admission.
- Any queries the patient or their next of kin/carer have will be answered promptly.
- The patient and their carer/next of kin will be advised of the assessment process.
- Nursing staff will orientate the patient to the ward and advise them of the daily routine including medication and meal times.
- A copy of the family/carer booklet will be provided to each family with relevant telephone numbers and names of key staff.

4.3.3 Initial Assessment

- The admitting nurse and doctor will commence the admission assessment.
- This assessment and plan of care will follow the patient's progress from admission to discharge and will provide information on multidisciplinary care.
- Patients and where appropriate, their family, will be actively encouraged to participate in the planning of their care.
- If the patient is admitted and detained under the Mental Health Order (NI) Order 1986. The detention process will be explained to them.
- The patient and their falily/carers will be given their Statement of Rights, this will be explained to them by the ASW.

- If the patient is admitted on a voluntary basis, the expectations of their engagement in assessment and treatment will be discussed and agreed with them and their family/carers.
- All patients and their family/carers will be advised of the advocacy service.

A number of sources of information will be referred to in completing the assessment: -

- The patient;
- The next of kin/main carer;
- The referrer
- Patients GP
- Previous inpatient notes (electronic or written)
- In cases where the patient is already involved with services their key worker in the community;
- Other relevant services.

- During the assessment the admitting nurse and doctor will also obtain information regarding any caring responsibilities the patient has i.e. young children or dependants or animals.
- Should any concerns regarding child protection/ child care arise staff will complete a UNOCINI referral form and send to Gateway Services, Family and Child Care.
- Should any concerns regarding care responsibilities for an elderly person, an adult safeguarding referral will be made to their local social services team.
- It is good practice to obtain the patient's consent to share information with others, including family members/carers/next of kin.
- Any services involved with the patient prior to their admission will be advised as soon as possible, as to their admission, preferably within the 2 working days.
- A representative from the community team will attend the first multidisciplinary team meeting which will take place within seven days of the admission.

4.3.4 Post Initial Assessment

- The patient will be seen by a consultant psychiatrist within 48 hours of admission.
- Patients and their next of kin/carers will be informed of the names of multidisciplinary team members involved in their care.
- The process of assessment and treatment will be evidence based, person specific, determined on the basis of a multidisciplinary formulation of needs and taking account of expressed preference and principles of best practice and provided in the least restrictive environment appropriate for safe management.
- In all cases informed consent will be sought before treatment is given. The Principles outlined in the Department of Health, Consent to

Examination or Treatment/Good Practice in Consent: Implementation Guidance.
- Where the patient is assessed as not having capacity, treatment and care will be determined on the basis of best interest or the relevant section of the Mental Health Order (NI) Order 1986 and will be mindful of the patients rights and will be inclusive of the family/carer..

4.3.5 Admissions of Under 18s to adult learning disability inpatient facilities

- Any patient under 18 years old will only be admitted to an adult ward within Learning Disability Services following a clinical risk assessment which ascertains that the risk is too high for them to remain in or be admitted to the Children's ward
- Upon admission to an adult ward the individual patient will commence observations i.e. that a designated member of staff is allocated to supervise the patient 24 hours a day.
- Such an admission will be recorded as an adverse incident on the Trust's DATIX system and admitting staff will notify the Hospital Services Manager of the admission.
- Medical records staff will advise relevant external agencies i.e. RQIA and other Trusts.

4.4 Discharge

4.4.1 Discharge

- Planning for discharge will begin at the point of admission
- The care plan will include a record of discharge planning processes.
- If there is not an identified discharge location, this will be escalated by the Community Care Manager to the appropriate Community Service Manager and by the RMO to the Hospital Services Manager.
- Discharge planning will involve community teams and relevant others including the patient and their next of kin/carer as appropriate and will form a part of every multidisciplinary team meeting.
- A discharge planning meeting will be arranged involving the inpatient MDT, community staff and any relevant others.
- The Comprehensive Risk Assessment in line with Promoting Quality Care Guidance will be reviewed prior to discharge.
- Medical staff will complete a medical summary which will be sent to the GP and relevant community staff within 14 days of the patient's discharge.
- If admission has been due to the breakdown of a community placement, an SEA will be conducted by te responsible community Care Manager and actions taken to identify what needs to be carried out to avoid reoccurrence.

4.4.2 Unplanned Discharge

Should a patient leave hospital, the Contrary to medical Advice (CTMA) protocol will be implemented.

4.4.3 Delayed Discharges

Medical records will be immediately updated when the MDT has agreed a patient is ready for discharge. The length of time between being deemed fit for discharge and actual discharge will be tracked by the Trust.

Patients delayed in discharge where treatment is complete, will be reported to the Health and Social Care Board by Medical Records, Muckamore Abbey Hospital

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy will be disseminated to all staff within inpatient Learning Disability Adult Services.

5.2 Resources

The policy will be shared with all staff as part of their induction

5.2 Exceptions

This policy is not relevant to inpatient forensic admissions.

6.0 MONITORING

This policy will be reviewed every 5 years

The implementation of this policy will be monitored by the senior management team.

7.0 EVIDENCE BASE / REFERENCES

This policy supports the principles of The Royal College of Psychiatrists Council Report on inpatient psychiatric care for young people with severe mental illness

The Report of the inquiry Panel (McCleery) to the Eastern Health and Social Services Board 2006;

The Report of the Inquiry Panel (McCartan) to the Eastern Health and Social Services Board 2007;

The Report of the Inquiry Panel (O'Neill) to the Eastern Health and Social Services Board 2008;

Mental Health (NI) Order 1986

8.0 CONSULTATION PROCESS

7.0 CONSULTATION PROCESS

This Policy has been developed following consultation with: -
Belfast Trust Learning Disability Services
add

9.0 APPENDICES / ATTACHMENTS

To be tabulated here and attached below as required.

10.0 EQUALITY STATEMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if this policy/proposal has potential impact and if it will be subject to a full impact assessment. This process is the responsibility of the policy or service lead - the template and guidance are available on the Belfast Trust Intranet. Colleagues in Equality and Planning can provide assistance or support.
The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☐

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise will be carried out to ascertain if this policy will be subject to a full impact assessment (see Appendix 7). The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link**.
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) will go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES
(Policy – Guidance will be signed off by the author of the policy and the identified responsible Director).

______________________________ **Date:** ______________________
Authors

______________________________ **Date:** ______________________
Director

A Review of Leadership & Governance at Muckamore Abbey Hospital

The Muckamore Abbey Hospital Review Team

31 July 2020

Executive Summary

1. The confidence of families and carers in the health and social care system's ability to provide safe and compassionate care was significantly undermined by the abuse of patients at Muckamore Abbey Hospital (MAH) which came to light in 2017. An Independent Review Team was commissioned by the Health and Social Care (HSC) Board and Public Health Agency at the request of the Department of Health to review leadership and governance arrangements within the Belfast HSC Trust between 2012 and 2017 to ascertain to what degree, if any, said leadership and governance arrangements contributed to the abuse of vulnerable patients going undetected. An Independent Team was appointed in January 2018 to conduct a level three Serious Adverse Incident (SAI) investigation of patient safeguarding at MAH. The outcome of that review, the *A Way to Go* report, was published in November 2018. The Department of Health (DoH) considered that that report had not explored leadership and governance arrangements at MAH or the Belfast HSC Trust sufficiently. The current review commenced in January 2020.

2. MAH opened in 1949 as a regional hospital for children and adults with learning disabilities. Initially, the hospital principally provided long-term inpatient care. In 1984 the Hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients. During the 1980s the policy direction was to provide care for people with learning disabilities within the community. From that time the intention was to reduce the number of patients and to develop resettlement options. The 1992/97 Regional Strategy established three targets: 'develop a comprehensive range of support services by 2002; have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and reduce the number of adults admitted to specialist hospitals.' Progress was slow but following the Bamford Reviews and the 2011 publication of Transforming Your Care, targets were established to close long-stay institutions and complete resettlement by

2015. The rate of ward closures and the numbers resettled progressed significantly with targets monitored for compliance. The current review took place within the context of retraction and resettlement which had significant implications for staffing, patients, and their relatives and carers. By July 2020 there were fewer than 60 patients at MAH.

3. The Review Team conducted the review by examining a range of Trust documents and by interviewing key staff at Muckamore Abbey Hospital, Belfast Health and Social Care Trust, the Health and Social Care Board and Public Health Agency, and the Department of Health. It also visited MAH during February 2020 and met staff and patients during visits to the wards. The Review Team met with a number of parents, advocates, a Member of Parliament, the PSNI, the Regulation and Quality Improvement Authority (RQIA), the Patient and Client Council (PCC), the Permanent Secretary of the Department of Health, and the Health Minister. Representatives of the Review Team also had the opportunity to attend a meeting of the Muckamore Abbey Departmental Advisory Group. The Review Team acknowledges the cooperation afforded to them by all those they met. It regrets that due to the Covid-19 lockdown it was not able to meet with more patients, relatives, and carers. Only three retired members of staff did not meet with the Review Team for a number of reasons.

4. The Belfast HSC Trust is one of the largest integrated health and social care organisations in the UK. It has appropriate governance structures in place with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care. The Trust Board and Executive Team rarely had MAH on their agendas. Issues which were discussed at that level generally focused on the resettlement targets. The annual Discharge of Statutory Functions Reports did not provide assurance on the degree to which statutory duties under the Mental Health Order 1986 were discharged. The Review Team saw no evidence of challenge at Trust, HSC Board, or Department of Health level regarding the adequacy of these reports. The Review Team was informed that matters came to the Trust Board on an issue or exceptionality basis and that the acute hospital agenda dominated. In

addition, the Review Team was advised that the emphasis was on services rather than facilities, such as MAH. The comprehensive governance arrangements were not a substitute for staff at both MAH level and Director level in the Trust exercising judgment and discernment about matters requiring escalation. The Review Team was informed that there was a high degree of autonomy afforded to Directors and senior managers given the scale of the Trust's operation. The Review Team concluded that there was a culture within MAH of trying to resolve matters on-site. The location of MAH at some distance from the Trust and the lack of curiosity about it at Trust level caused the Review Team to view it as a place apart. Clearly, it operated outside the sightlines and under the radar of the Trust.

5. The leadership team at MAH was dysfunctional with obvious tensions between its senior members. There was also tension around the intended future of the hospital with some managers viewing its future as a specialist assessment and treatment facility while others perceived it as a home for patients; many of whom had lived in the hospital for decades. There was a lack of continuity and stability at Directorate level and a lack of interest and curiosity at Trust Board level. Visits of Trust Board members and other Directors to MAH were infrequent. Leadership was not visible. The Review Team was told that staff at MAH were not always clear which Trust Director had responsibility for services on-site. As the *A Way to Go* report noted, staff felt a loyalty to one another rather than to the Trust. Leadership was also found wanting at Director level as issues relating to the staffing crisis at MAH and its impact on safe and compassionate care were not escalated to the Executive Team or Trust Board as a means of finding solutions. One Director told the Review Team of his efforts to undertake regular walkabouts at MAH as a means of understanding the issues confronting staff and patients. Other Directors referred to occasional visits to the site but not on a structured or regular basis. The value base of the Belfast Trust is well articulated in its strategies and leadership frameworks. Unfortunately, there were no effective mechanisms in place to ensure that these values were cascaded to staff at MAH. The value base of some staff was antithetical to that espoused by the Trust as an organisation.

6. The Review Team considered three events at MAH to structure its review of leadership and governance. The first was the Ennis investigation which commenced in November 2012 following complaints from a private provider's staff about physical and verbal abuse of patients in the Ennis Ward. The investigation was carried out jointly with the police under the Trust's adult safeguarding and the Joint Protocol processes. It resulted in two staff members being charged with assault. One staff member was not convicted while the other's charge was overturned on appeal. The investigation took eleven months to produce a final report. The Review Team considered the Ennis investigation to be a missed opportunity as it was not escalated to Executive Team or Trust Board levels for wider learning and training purposes. It was not addressed in the Discharge of Statutory Functions Reports nor was there evidence in the documentation examined that its findings were disseminated to staff and relatives/carers. The Review Team considered that the Ennis Investigation merited being addressed as an SAI, as a complaint, and as an adult safeguarding matter. Each of these additional processes would have provided a mechanism to bring matters at Ennis to the Trust Board. The HSC Board for some considerable time pressed the Trust to submit an SAI in respect of Ennis. When the Trust accepted that it was in breach of requirements by not conducting an SAI, the Board let the matter rest. The Review Team considered the situation at Ennis to be an example of institutional abuse. Learning from Ennis therefore had the potential to identify any other institutional malpractice at an earlier stage.

7. The second issue considered by the Review Team was the installation of CCTV initially at Cranfield in the male and female wards and in the Psychiatric Intensive Care Unit (PICU), as well as in the Sixmile wards. The concept of installing CCTV for the protection of patients and staff was first raised around August 2012. A business case was developed and approved in 2014. In 2015 CCTV cameras were installed in Cranfield and Sixmile wards. From an extensive examination of all documentation, the Review Team concluded that the CCTV system was operational and recording from July 2015. There was no policy nor procedure to inform the use of CCTV. The

Review Team identified extensive delay in finalising a CCTV policy; some 25 months after the cameras were installed. During July/August 2017 notices were displayed in Cranfield and Sixmile wards advising that the CCTV cameras would become operational from the 11th September 2017.

8. The Trust paid for regular maintenance of the cameras following their installation. The system on which the CCTV cameras operate is one where the cameras are triggered by motion. Recordings are due to overwrite after 120 days. Due to the motion activation of the cameras it is likely that recordings were of longer duration than the 120 days. The Review Team concluded that the footage now available had overwritten previous footage.

9. CCTV footage in late August/early September 2017 revealed abuse and poor practice in several of the wards. The CCTV cameras had been recording for a considerable amount of time, apparently without the knowledge of staff or management. The discovery of historical CCTV recordings prompted by the intervention of a concerned parent, revealed behaviours which were described as very troubling, professionally and ethically, which were morally unacceptable and indefensible. It is apparent from extensive discussion with staff at all levels that there was no awareness that the cameras were operational. The MAH staff member (retired) most likely to be in a position to clarify matters regrettably did not respond to the request to meet with the Review Team.

10. The existence of CCTV recordings was reported to senior staff at the Trust's HQ on 20th September 2017. This was at least two to three weeks after the situation was identified at MAH. Immediate steps were taken at Trust Executive Team level to inform the police about the existence of CCTV footage in relation to an alleged assault which occurred on 12th August 2017 as well as other incidents. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions; at least 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. Despite

the scale of the abuse it is important to note that carers and families have frequently attested to the care and professionalism of many staff working at MAH.

11. The third incident considered was a complaint about an assault on a patient at PICU which occurred on 12th August 2017. This assault was not reported to the patient's father until 21st August 2017. The father was understandably concerned about the delay in notifying him especially as he was used to being regularly contacted by the staff about his son. A thorough review of all of the evidence led the Review Team to conclude that the delay in notifying the father was due to a breach of the Trust's adult safeguarding policy rather than an attempt to hide misdoings. The incident of the 12th August 2017 was immediately reported by a staff nurse who witnessed it. The Nurse in Charge failed to initiate the adult safeguarding arrangements at that time. Instead he emailed the Deputy Charge Nurse (DCN) seeking to meet in order to discuss a concern. At the meeting on the 17th August the DCN considered the information to be vague and emailed the staff nurse for details as he was on leave. As soon as matters were brought to the attention of the Charge Nurse on 21st August all appropriate action was taken in a timely manner, including notification to the patient's father.

12. Following a meeting with MAH staff on 25th August the father complained to the Trust. Due to an incorrect email address, this was not received by the Complaints Department until the 29th August. In a letter to the father dated the 30th August 2017 he was advised that at the completion of the safeguarding investigations any outstanding matters could be addressed through the complaints procedure. The safeguarding investigation concluded in November 2018. The complaint remains open and incomplete. The Review Team considered this unacceptable.

13. The Review Team intended to visit centres of excellence to provide comment on best practice. Due to lockdown this was not possible. The Review Team has however, provided comment which it considered appropriate to the development of a person-centred rights based model of care for patients in learning disability hospitals.

14. The Review Team concluded that the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation. This failure resulted in harm to patients. The Review Team concluded that while senior managers at MAH may not have been aware of the culture of abuse, that their responsibility for providing safe and compassionate care remained. The Review Team made twelve recommendations to the Department, HSC Board, and the Trust in order to improve future practice. These recommendations took account of the improvements already implemented by the Trust.

15. The Review Team acknowledges the recent efforts made by the Belfast HSC Trust to promote and monitor a safe person-centred environment at MAH.

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1. Introduction

1.1 At the request of the Department of Health (DoH), the Health and Social Care Board (HSCB) and Public Health Agency (PHA) commissioned a review to examine critically the effectiveness of the Belfast Health and Social Care Trust's (Belfast Trust) leadership and governance arrangements in relation to Muckamore Abbey Hospital (MAH).[1] The review's remit spans the period from 2012 to 2017.[2] This five year period preceded serious adult safeguarding allegations that came to light in August 2017. Under its Serious Adverse Incident policy the Belfast Trust commissioned a review into these allegations by appointing a team of independent experts in January 2018.

1.2 The expert team in November 2018 published its report, *A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital.* The HSCB/PHA and the DoH concluded that leadership and governance issues in MAH and within the Belfast Trust merited further examination. It was therefore decided that a further review focusing on leadership and governance be conducted in order to 'establish if good leadership and governance arrangements were in place and failed, and, if so, how/why; or were effective systems not in place.'[3]

1.3 A complaint and allegations made in 2017 that vulnerable patients were physically and mentally abused by staff at Muckamore Abbey Hospital resulted in the police and the Belfast Trust initiating investigations under the Trust's Safeguarding of Vulnerable Adults policy, Complaints policy, and its Serious Adverse Incident policy. A considerable volume of video evidence exists in relation to the alleged abuse; the PSNI has a lead role in these investigations given their criminal nature.

[1] Terms of Reference, Appendix A(i)
[2] During that period there were three key events around which the Review Team focused its attention: November 2012 allegations made regarding the care and treatment of patients in the Ennis Ward; August 2017 complaints by a parent regarding his son's care; and August 2017 the identification of video recording regarding the care and management of patients.
[3] Purpose of Review, Terms of Reference, January 2020

A number of MAH staff and ex-staff have subsequently been arrested, some of whom have been referred to the Public Prosecution Service (PPS), while others have been suspended from their jobs. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions, 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. The PSNI has confirmed that the scale of the evidence has required the establishment of a dedicated investigation team.

1.4 During 2018/19 the Belfast Trust and DoH set up a series of measures to address the serious allegations and evidence that was emerging regarding the safety of patients at MAH. This included the establishment of: the *Way to Go* Review Team by the Belfast Trust; as well as the Muckamore Abbey Hospital Departmental Assurance Group (MDAG) jointly chaired by the DoH's Chief Social Services Officer and the Chief Nursing Officer.

1.5 From the outset the leadership and governance Review Team decided to accept the safeguarding concerns raised in the following reports, rather than re-examine these events:

- November 2012 in the Ennis Ward;
- the incidents evident in CCTV footage available from March to August 2017; and
- the complaint made by a patient's father in August 2017 regarding his son's alleged abuse by staff.

The Review Team has accepted these events as key events in its review of governance and leadership and will consider them within that context in Section 8 of the report.

2. Terms of Reference

2.1 The Terms of Reference (ToR) were agreed between the HSCB/PHA and the Department in consultation with the MDAG. The full Terms of Reference are available at Appendix 1. The ToR can be summarised as follows:

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to the quality, safety and user experience. Drawing upon families, carers and staff's experience; conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

- *Strategic leadership across the Belfast Trust.*
- *Operational management*
- *Professional / Clinical leadership*
- *Governance*
- *Accountability*
- *Hospital culture and informal leadership*
- *Support to families and carers*

2.2 The ToR also requires that the Review Team:

- interview key individuals and scrutinise relevant documentation;
- establish lines of communications with all the organisations impacted by the review; and
- act fairly and transparently and with courtesy in the conduct of its work.

3. The Review Team

3.1 The HSCB and PHA established a three-person review team with organisational, clinical, and professional expertise from their previous work experiences within health and social services in Northern Ireland. Review Team members comprised:

David Bingham

Maura Devlin

Marion Reynolds

Katrina McMahon – Project Manager

Appendix 2 sets out brief curriculum vitae in respect of each of the Review Team members.

4. Methodology

4.1 The methodology provided by the HSCB/PHA was based on the establishment of a team of independent members with extensive experience of leadership and management within the health and social care sector (See Para 3.2).

4.2 The Review Team's first task was to establish lines of communication with all those likely to be impacted by the review. The Belfast Trust was the main focus of the review. Others contacted included: the DoH; HSCB; PHA; RQIA; families and carers as well as their representatives; advocacy services; the Patient and Client Council (PCC); other HSC Trusts with patients in MAH; and the PSNI.

4.3 The Review Team met with senior staff from each of these organisations and a number of family members. On 21st February 2020 the Review Team visited MAH to meet with patients and staff. The Review Team determined the type and range of documentation required to establish the policies and operational protocols extant during the period under review. The Belfast Trust was asked to provide extensive documentation to enable the Review Team to assess its governance and leadership arrangements. This included Trust policies on controls assurance, management of risk, complaints, and serious adverse incidents. Details of organisation charts, minutes of management, Directorate, and Board meetings were also sought. The Review Team experienced some difficulty in acquiring documentation due to Lockdown. Other organisations were also asked to provide relevant documentation. The list of documentation examined by the team is set out in Appendix 3

4.4 Having examined documentation furnished by the Belfast Trust the Review Team met with key individuals in the Trust and other organisations. It also identified further documentation it required. The purpose of these interviews was to establish how leadership and governance were exercised between 2012 and 2017 and to

ascertain the degree of adherence with extant policies and protocols. A list of those interviewed is provided in Appendix 4. Three retired senior managers of the Belfast Trust did not engage with the review process:

- a retired Service Improvement and Governance manager and Co-Director of Learning Disability Services at MAH[4] replied to a request to meet with the Review Team stating she was not willing to participate;

- a retired co-Director for Learning Disability Services who retired from the service in September 2016 would not meet with the Review Team as his request to the Trust for an extensive range of documents to examine prior to interview was not met. He requested that the Review be extended in order to facilitate his review of documents. This request could not be met by the Review Team due to the time frame set for completion of this Review and the view that his request for an extension was unreasonable;

- a retired Business and Service Improvement Manager at MAH made no response to repeated requests, made through the Trust, for an interview with the Review Team.

In each of these cases the Review Team informed the individual that it would reach its conclusions on the basis of the documentary evidence available to it and comments made by other interviewees. A former Chief Executive of the Trust was also not available for interview within the time scale set for the Review. The Review Team regrets that its conclusions were not informed by input from these individuals.

[4] Service Improvement and Governance until October 2016 when then promoted to Co-Director for Learning Disability Services

4.5 A timeline for the Review was established by the HSCB and PHA. The Review Team commenced its work in January 2020 with an agreed target date of 30th April for an interim report with the full report being produced by 30th June 2020. It was recognised that there was a particular urgency to this work given the need to reassure family members, carers, staff, and the public that the serious safeguarding issues that had arisen in MAH had been identified and addressed, and that lessons had been learned and acted upon.

4.6 The lockdown and social distancing measures that followed the start of the Coronavirus pandemic in March 2020 meant that the Review Team had to suspend its work for a period of six weeks. The Review Team resumed its examination of documents and interviews in mid-April 2020 using online conferencing technology, namely Zoom. The HSCB/PHA set a new date for a final report of 31st July 2020. It was also agreed that the interim report stage would be omitted to minimise the delay in delivering the Review Team's report. Plans to visit centres of excellence to inform Best Practice had to be shelved and replaced by a literature review.

4.7 During lockdown the Review Team was unable to meet with as many patients, relatives, and friends as it would have wished. It deeply regrets that it was unable to meet with more service users. It did, however, benefit from interviews with:

- three parents/relatives;
- The Chair of Friends of Muckamore Abbey;
- representatives of Bryson House and Mencap which provide advocacy services to patients at MAH; and
- a representative of the Patient and Client Council which the Department had engaged to provide independent support for Families and Carers who became involved with the review process.

Representatives of the Review Team attended one meeting of the Muckamore Abbey Departmental Advisory Group in March 2020. The Review Team also issued a general invitation through a representative of the Action for Muckamore group, to meet with any relatives/carers who wished to meet either in person or via Zoom. No further requests for interview were received.

4.8 The Review Team would appreciate an opportunity to meet with patients, relatives and carers at the conclusion of the Review to provide feedback to them about its conclusions and recommendations.

5. Background to Muckamore Abbey Hospital

5.1 This section provides a brief historical overview of Muckamore Abbey Hospital and the plan to resettle patients in community settings.

A. Muckamore Abbey Hospital – A Brief Historical Overview

5.2 Muckamore Abbey Hospital opened in 1949 as a regional service for children and adults with learning disabilities. It is located in a rural setting outside of Antrim town. The opening of the hospital enabled children and adults to be admitted over time from six mental health hospitals; some 743 patients of whom 120 were children.

5.3 Initially, the hospital principally provided long-term permanent inpatient care for its patients. Services provided have undergone significant changes over the years, reflecting evolving policy imperatives for people with a learning disability. The function of the hospital has therefore expanded over time to include: supervised activity for a minority of patients; return to the community; and a centre for medical research. 'Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patient living there long term.'[5]

5.4 The *A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go* report sets out a timeline for the hospital, from 1946 to 2016 which notes that nurse training began at the hospital in 1955; followed by the opening of a special needs teacher training college in 1963.[6]

[5] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 46
[6] Op. Cit., Pages 46 - 51

5.5 In 1966 Muckamore Abbey Hospital had 880 patients. By the late 1960s and early 1970s there was a growing realisation that treatment and training should take place outside of a hospital setting. There was also a problem with overcrowding at the hospital.[7] By 1980 the hospital had more than 20 units on its site. During 1984 the hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients.

5.6 From the 1980s attempts were made to provide care in the community for patients. The delivery of this objective was described as 'a very slow process'. 'We had targets and dates before [2015/16], and there was a lot of criticism that those were not met. We are talking about a long period; certainly, in my experience of work, from the 1980s to today.'[8] In 1986 a Rehabilitation Unit was established at the Hospital to promote a return of patients to community settings.

5.7 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy, Health and Wellbeing into the New Millennium, required that Boards and Trusts:

- develop a comprehensive range of support services by 2002, and
- have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and
- reduce the number of adults admitted to specialist hospitals.

The target established by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.[9]

[7] Ibid, Page 48

[8] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Mr. Aidan Murray, Page 6

[9] By that time, 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.

5.8 In 1993 the number of patients in the Hospital had reduced to 596. Despite the Regional Strategy the hospital argued for the retention of a specialist Assessment and Treatment service on the site. In 1994 a Forensic Unit was also established. The *A Way to Go* Report noted that, 'by the mid-1990s the presence of adolescents on adult wards had become a significant problem.'[10] The removal of children from the Hospital was achieved with the establishment of the Iveagh Centre an inpatient service for children.

5.9 In 1998 Pauline Morris' study of long stay hospitals for patients with a learning disability was published.[11] The study criticised the medical model of care and recommended a socio-therapeutic model in which training was deemed as important as nursing and medical functions. There was however, a lack of community resources in Northern Ireland to support the discharge of long-stay patients from the hospital. It was therefore acknowledged that patients who had been resident for 30 to 40 years would remain in hospital.

5.10 Due to inappropriate living conditions seven of the hospital's wards were closed in 2001. Around this time a survey of admissions to the hospital found, 'that most admissions … were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.'[12] In 2003 a business case for a new core hospital was submitted to the Department. This resulted in the building of a 35 bed Admission and Treatment Unit and a 23 place Forensic Unit. Both facilities were completed in 2006/07 at a cost of £8.4m. The hospital at that time had three distinct patient treatment groups:

- Admissions and Treatment;
- Resettlement; and

[10] Ibid, Page 49
[11] Morris, Pauline Put Away: A Sociological Study of Institutions for the Mentally Retarded Taylor & Francis, 2003 First Published in 1998
[12] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 49

- Delayed discharges.

5.11 In 2002 the Department of Health, Social Services and Public Safety (DHSSPS) established the Bamford Review to inquire into the law, policy, and services affecting people with a mental illness or a learning disability. A key message emerging from the Bamford Review was an emphasis on a shift from hospital to community-based services. The second report from the Bamford Review, *'Equal Lives',* published in 2005, set out the Review's vision for services for people with a learning disability which envisaged that hospital should not be considered as a home for learning disabled people. *Equal Lives* 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 1st April 2007 were defined as Priority Target List patients. There have been two Action Plans (2009-2011 and 2012-2015) created to take forward the Bamford Review's recommendations.

5.12 In 2005 the Hospital had 318 patients and a target was set that this would reduce to 87 by 2011. By December 2011 however, 225 patients remained.[13]

5.13 In 2011 The Minister for Health published *Transforming Your Care: A Review of Health and Social Care (TYC)*[14]. TYC sets out 99 proposals for the future of health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. It restated the Bamford Review commitment to closing long-stay institutions and completing the resettlement programme by 2015.

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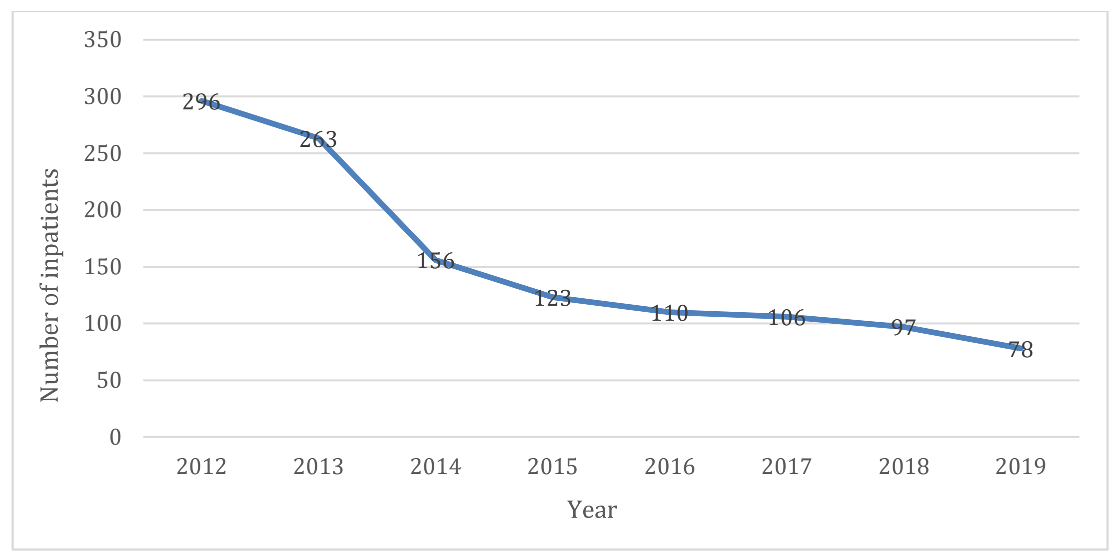
[13] Ibid, Page 50

[14] http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

5.14 As part of the TYC agenda a central feature of the Department's plans for the reform of the health and social care system in Northern Ireland was the move from hospital-based care towards an integrated model of care delivered in local communities, closer to people's homes. In addition to the TYC document, a draft Strategic Implementation Plan (SIP) was developed.[15] In terms of learning disabilities, the SIP focused efforts on resettlement, delayed discharge from hospital, access to respite for carers, individualised budgets, day opportunities, Directly Enhanced Services (DES), and advocacy services.[16]

5.15 As of April 2020 the Hospital has under 60 patients and operates from six wards[17] providing inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs, or challenging behaviour. From a regional hospital with more than 20 units and at one time over 1,400 patients, the hospital is now greatly reduced in both the number of wards and the number of patients. The following table[18] demonstrates the reduction in number of patients between 2012 and 2019:



[15] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40
[16] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40.
[17] Ardmore for female patients, Cranfield 1 and 2 for male patients, Sixmile Assessment and Sixmile Treatment wards which deal mainly with forensic patients, and Erne wards for male and female patients with complex needs.
[18] The figures in the Table include Iveagh Unit which is a 6 bed unit caring for children aged under 12 years of age.

5.16 Although originally a regional service, the hospital now largely serves the Belfast HSC Trust which manages it, and the Northern HSC Trust in whose area it is located, as well as the South-Eastern Trust. Remaining Trusts have arrangements in place to meet the needs of their learning disabled residents without recourse to the hospital.

B. Resettlement

5.17 Various plans and targets aimed at resettling patients from the hospital to community settings have been in place since the 1980s (see Paras 5.6 – 5.13). Since 1992 however, the Department's overarching policy direction has been the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey Hospital to community living facilities. In 1995 a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to community accommodation.

5.18 Efforts to secure this strategic objective in relation to the hospital are evident in the 1992/97 Regional Strategy, the Bamford Review (2002 and 2005), and TYC (2011) as well as associated action plans. The reasons for delay are complex and include:

- the difficulty in moving patients from a facility which they have regarded as their home. As noted in Para. 5.9 there was an acknowledgement that patients who had been resident for 30 to 40 years could remain in hospital;

- the lack of community resources to support the discharge of long-stay patients from the hospital;

- the fact that many people living with a learning disability have associated co-morbidities, such as physical and mental health conditions, including epilepsy and autism. Mental health conditions and certain specific syndromes may also be associated with other physical conditions and challenging behaviour. Patients currently remaining in the hospital have, therefore, very complex needs which makes their resettlement particularly challenging.

5.19 A senior Medical Adviser in her evidence to an Assembly Committee in 2013 set out the broad policy thrust of the Department of Health in relation to mental health and learning disability services. She stated that, 'in the January 2013 Bamford action plan that scopes 2012-15 - the emphasis across mental health and learning disability was on early intervention and health promotion; a shift to community care; promotion of a recovery ethos, largely in respect of mental health; personalisation of care; resettlement; service user and carer involvement; advocacy; provision of clearer information; and short break and respite care.'[19]

5.20 The evaluation of the second Bamford Action Plan 2013 - 2016 was completed in 2017. It found that the resettlement programme was nearing completion. Of the 347 long-stay patients in learning disability hospitals in 2007, only 25 remained in long-stay institutions in 2016. Since then further progress has been made. By early 2020 there were ten inpatients from the original Priority Target List remaining in the hospital, with a further individual undergoing a trial resettlement in the community.

5.21 The increased focus on the resettlement of patients driven forward by the Bamford Review and TYC resulted in the closure of wards and the bringing together of staff and patients into new living arrangements. The Review Team

[19] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Page 2

concluded that the focus on resettlement had a negative impact on the culture of the hospital with insufficient attention being afforded to the functioning of the inpatient wards.

5.22 The criticism that the 1980s resettlement objective was progressed slowly, was due in the Review Team's opinion, to the arrangements which were established to monitor delayed discharges and patient discharges post the Bamford Review. The scale of the resettlement achieved was significant with a decrease from 347 long-stay patients in learning disability hospitals in 2007, to 25 by 2016 and 10 by 2020. From the information available to the Review Team they concluded that the Belfast HSC Trust's focus was on its resettlement objectives rather than on the hospital in its totality.

5.23 The resettlement plan caused anxiety among the staff team. During its orientation visit to the hospital in February 2020 and afterwards in written comments made in 2012 by hospital staff, the Review Team found that in addition to anxiety around job security and staff recruitment, there were a number of concerns including:

- the adequacy of staffing levels and skill mix on wards;
- the staffing rota which was heavily supplemented by bank staff which led to tiredness and increased sickness levels;
- insufficient staffing to run the resettlement programme. An email sent in October 2012, to an Operations Manager (part-time) by a Sister in one of the Wards, stated that resettlement could not continue due to staffing levels;
- the resettlement process which increased workload in respect of assessments;
- patient activities which were curtailed due to staff shortages;
- the mix of patients' needs in wards which were at time incompatible and competing;

- the impact of some patients' behaviour on the dynamics of a ward and reservations expressed regarding the decision to place specific patients within a given ward;

There was also a view that the 'resettlement wards are not up to 21st Century standards'.

5.24 The drift associated with earlier resettlement plans from the 1980s was possibly also associated with the resistance of some staff and families to the plan to close the hospital. In the opinion of the Review Team this may explain why the post Bamford resettlement plans were advanced without the benefits of feedback systems capable of monitoring how the roll-out impacted upon matters such as: the operation of wards; staff sickness and absences; untoward incidents; and patient safety. Such a process would have ensured that core hospital functions could have been maintained safely while the resettlement model was progressed.

5.25 At the hospital there were two competing service models: a medical model which informed the core hospital services and a social care model focused on resettling patients into the community. The *A Way to Go* report noted the 'hospital requires focus regarding its role and place in the future of learning disability services in NI'.[20] The Welsh government's review of learning disability services stated that 'hospital is not a home'. It found: 'Patients were remaining in hospital units for a long time and were transferred between hospitals when alternatives in the community could have been considered. The average length of time was found to be five years, with one patient staying for 49 years. People should only stay in hospitals if there are no other ways to treat them safely.'[21]

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[20] *Way to Go, November 2018, Page 5, par. 5*
[21] Warmer, K. Hospitals should never be anyone's home, Published February 2020, Welsh Government https://www.ldw.org.uk/hospital-should-never-be-anyones-home/

5.26 Resettlement needs a cultural shift in thinking about the resourcing of learning disability services. It also requires an approach which provides adequate financial resources and community infrastructure to support resettlement objectives and to successfully maintain discharged patients in the community. Section 9 on Best Practice considers this cultural shift in greater depth.

5.27 In conclusion, in undertaking its review the Review Team wants to place the key events listed in Para. 1.5 and in Appendix 5 in the context of a comprehensive understanding of the hospital, its culture, and the resettlement programme which it actively pursued after the two Bamford Reviews.

6. Review of Governance

6.1 The following section considers:

i. what governance is

ii. corporate and clinical/professional governance

iii. the Effectiveness of Corporate and Clinical/Professional Governance

i. What governance is

6.2 In undertaking its review of governance the Review Team considered a range of definitions and guidance which was available at all levels within the Health and Social Care system in Northern Ireland in order to decide on which definition to use to inform its examination of the Trust's governance structures and arrangements.

6.3 The Social Care Institute for Excellence (SCIE) notes that the quality of services provided are the responsibility of individual staff members and their employers: 'Every staff member has, responsibility for providing good quality social care. Social care governance is the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[22]

6.4 More organisationally focused definitions conceive of governance as 'a framework within which health and personal social services organisations are accountable for continuously improving the quality of their services and taking

[22] Social care governance: A practice workbook (NI) 2nd edition, SCIE, 2013, Page 1
http://www.belfasttrust.hscni.net/pdf/Social-Care-Institute-for-Excellence-Social-care-governance.pdf

corporate responsibility for performance and providing the highest possible standard of clinical and social care' (Best Practice, Best Care, DHSSPS, 2002[23]).

6.5 The Department of Health (DoH) cites in its Introduction to Governance[24] Her Majesty's Treasury (HMT): 'the system by which an organisation directs and controls its functions and relates to its stakeholders.' DoH noted that this influenced the way in which organisations:

- manage their business;
- determine strategy and objectives; and
- go about achieving these objectives.'[25]

6.6 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland.[26] To facilitate the achievement of service improvements the Quality Standards for Health and Social Care were published in 2006. These standards require governance arrangements which 'must ensure that there are visible and rigorous structures, processes, roles, and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.'[27]

6.7 The Quality Standards also require the RQIA to commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five quality themes

[23] https://www.scie-socialcareonline.org.uk/best-practice-best-care-the-quality-standards-for-health-and-social-care/r/a11G000000182tdIAA
[24] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[25] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[26] Article **34.**—(1) Each Health and Social Services Board and each **[**F1HSC trust**]** shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—
(a)the health and **[**F2social care**]** which it provides to individuals; and
(b) the environment in which it provides them. http://www.legislation.gov.uk/nisi/2003/431/article/34
[27] The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, Page 1, par. 1.3, March 2006 https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

contained within them.[28] This enhanced the RQIA's general duty of encouraging improvements in the quality of services commissioned and provided by the HSC by promoting a culture of continuous improvement and best practice through the inspection and review of clinical and social care governance arrangements.[29]

6.8 The Quality Standards comprise three key themes, one of which is clinical and social care governance. The Quality Standards note that to promote service improvements 'clinical and social care governance … must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments.'[30]

6.9 Standard 1 of the Quality Standards, Corporate Leadership and Accountability of Organisation, has as its Standard Statement: 'The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.'[31]

6.10 The criteria by which compliance can be assessed are:

a) 'has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

[28] Ibid, Page 5 par. 1.7 and 1.9 Quality themes: 1. Corporate Leadership and Accountability of Organisations; 2. Safe and Effective Care; 3. Accessible, Flexible and Responsive Services; 4. Promoting, Protecting and Improving Health and Social Well-being; and 5. Effective Communication and Information.
[29] Ibid, Page 4, par. 1.8
[30] Ibid, Page 6, par. 2.1
[31] Ibid, Page 10, par. 4.2

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation

k) undertakes robust pre-employment checks including: qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body:

- police and Protection of Children and Vulnerable Adults checks, as necessary;
- health assessment, as necessary; and references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.'[32]

6.11 The Review Team considered the Quality Standards approach appropriate to its task, particularly as these were the basis upon which the RQIA served four Improvement Notices in respect of failures to comply on the Belfast HSC Trust in

[32] Ibid, Pages 10 -11, par. 4.3

November 2019. The Quality Standards require governance arrangements which: 'must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care' (see Para 6.6). By doing so the Review Team will be facilitated by having access to a number of the criteria established (see Para 6.10) to determine the robustness of the Trust's governance arrangements objectively.

ii. Corporate and Clinical/Professional Governance

6.12 The Review Team considered corporate and clinical/professional governance arrangements within the Trust as it related to MAH.

Corporate Governance

6.13 The Trust was formed under the Belfast Health and Social Services Trust Establishment Order (Northern Ireland) 2006. It came into existence on 1st April 2007 with the merging of six Trusts, namely:

- the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
- the Mater Hospital Health and Social Services Trust
- North and West Belfast Health and Social Services Trust
- South and East Belfast Health and Social Services Trust
- Green Park Health and Social Services Trust
- Belfast City Hospital Health and Social Services Trust.

6.14 The Belfast HSC Trust is a complex organisation with an annual budget of over £1.3bn and a workforce of over 20,000 full time and part time staff. It is one of

the largest integrated health and social care Trusts in the United Kingdom delivering integrated health and social care to approximately 340,000 citizens in Belfast. In order to ensure the best possible delivery of these services they have been grouped into ten Directorates. The Trust also provides the majority of regional specialist services in Northern Ireland and comprises the major teaching and training hospitals in Northern Ireland. The following section considers governance under two headings:

A. Organisational Structures; and
B. Information Systems.

(A) Organisational Structure

6.15 The Belfast Trust provides a range of disability services in the community, at home, and in hospitals. The Review Team examined the systems and information systems established by the Belfast HSC Trust to enable it to assure 'the quality of services that it commissions and provides to both the public and its staff' in respect of the services provided at MAH (see Para 6.9). The Trust's organisational structure in 2012/13 encompassed the following:

- a Trust Board of five Executive Officers and seven non-Executive Directors, including the Chairman. Accountable directly to the Board were four committees (Remuneration, Charitable Trust Funds, Audit, and Assurance) which met on a bi-monthly basis. The Executive consists of the Chief Executive and the Executive Directors of Finance, Medicine, Social Work, and Nursing. The Board is responsible for the strategic direction and management of the Trust's activities. It is accountable, through its Chairman, to the Permanent Secretary at the Department of Health and ultimately to the Minister for Health;

- the Executive Team which is accountable to the Trust Board in regards to the day to day operational management and development of the Trust. It meets on a weekly basis. It receives reports from Executive and Operational Directors based on information received from Co-Directors who have operational responsibility for service areas such as: Learning and Disability Services; Mental Health; and Health Estates. Information was also provided from the Assurance Group;

- an Assurance Group. The Trust's Assurance Framework sets out the committee structures for Clinical and Social Care Governance and risk management. The Framework describes the mechanisms to address weaknesses and ensure continuous improvement, including the delivery of the delegated statutory functions and corporate parenting responsibilities. Five groups report to The Assurance Group:

  - the Governance Steering Group, which covers 15 areas including: risk management; policies; control assurance; and information governance. The steering group was served by two sub-committees;

  - a Safety and Quality Steering Group which was served by five sub-committees;

  - a Serious Adverse Incident (SAI) Board which reviewed each SAI;

  - a Social Care Steering Group which was served by three sub-committees; and

  - an Equality, Engagement and Experience Steering Group which was served by three sub-committees.

6.16 The organisational governance structure remained largely consistent throughout the 2012 to 2017 period covered by the Review Team's Terms of Reference. The only change to the structure, which occurred in 2013/14, was that the SAI Group was merged with the Governance Steering Group; no longer was it a stand-alone entity. In the 2015/16 business year the Social Care Committee structure was altered so that it had a direct relationship with the Trust Board.

6.17 Structurally therefore the Belfast HSC Trust had arrangements in place capable of assuring the quality of the services which it provided. The structure is complex with a significant number of Committees, Steering Groups, and Sub-Committees. This structure placed significant demands and challenges on senior and middle management staff. The range of services provided by the Trust and their complexity inevitably requires systems which are complex.

6.18 The change to the status of the Serious Adverse Incident (SAI) Group in 2013/14 outlined in par. 6.15 may have contributed to the failure to address the Ennis complaint as an SAI. The allegations made in respect of staff's management of patients in Ennis ward made in November 2012 were dealt with under the Trust's Safeguarding Vulnerable Adults Policy. This meant that the ensuing investigation focused exclusively on the allegations as a means of acquiring the evidence in order to either substantiate the allegations or to discount them. Wider issues relating to the organisation of services, pressures within the Ennis ward in terms of caring for patients with complex and at times conflicting needs, the adequacy of staffing, and the skill mix available to care for patients were not subject to fuller investigation.

6.19 From email correspondence between the HSC Board's Deputy Director and the Trust dated between the 6th February 2013 and the 3rd September 2015 it is apparent that repeated requests from the Board for the Ennis allegations to be dealt with as an SAI were not met. In September 2015 the HSC Board wrote

asking that the Trust accept that this was a breach of requirements. On 7th September 2015 the Trust responded accepting that it was in breach of the SAI procedures [both the 2010 and 2013 procedures] but 'as the allegations were not substantiated by the safeguarding investigation it was content to live with the procedural breaches.'

6.20 At MAH level governance arrangements were also in place during the period under review. On site was a Service Improvement and Governance member of staff. On a weekly basis the Trust's Co-Director for Learning Disability Services convened a multidisciplinary meeting at MAH comprising the Service Improvement and Governance manager and hospital and community staff.

6.21 The minutes of these meetings show that they were well attended by all staff and comprehensive minutes were taken of the proceedings. A community-based social worker regularly attended these meetings as one of her duties was to complete the Statutory Functions Report for the learning disability programme of care.[33] None of the minutes examined provided information on the following:

- the information which would be provided to the HSC Board in respect of the Discharge of Statutory Functions; or
- issues arising from the Ennis investigation and follow-up actions.

6.22 Information was available on the receipt of RQIA inspection reports; there was, however, no indication from the MAH records examined that findings from these inspections were viewed as negative or requiring remedial action. This finding is confirmed by an examination of governance meetings chaired by the Service

[33] The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions (DSFs) from Health and Social Care Trusts (Trusts) to the Health and Social Care Board (HSCB) and ultimately to the Department of Health, Social Services and Public Safety (Department) has been in place since 1994. The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the Trusts are individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs. CIRCULAR (OSS) 4/2015: STATUTORY FUNCTIONS/PROFESSIONAL OVERSIGHT https://www.health-ni.gov.uk/sites/default/files/publications/health/CIRCULAR%28OSS%29-4-2015.pdf

Improvement and Governance manager. The minutes regularly reference an RQIA announced or unannounced inspection at wards within the hospital. From these minutes information was not available to indicate any serious concerns being raised by the Regulator. As noted in Para. 6.11 it was not until November 2019 that RQIA served four Improvement Notices in respect of failures to comply on the HSC Trust, in respect of the MAH site. Improvement Notices had previously been served on Iveagh which was the children's disability service. The Review Team was advised by RQIA that there was significant learning emerging from its inspection of Iveagh which, had it been applied, could have improved practice at MAH. The Review Team found that issues arising from complaints and incidents or RQIA reports were not discussed. Therefore they did not inform the education plans for staff in MAH.

(B) Information Systems

6.23 The only way in which any organisation can know how it is performing is to have access to all the relevant data describing its performance in meeting the relevant legislation and regulatory and professional standards. As the inquiry into the practice of breast surgeon Dr Ian Patterson noted: 'it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used, and then made available to the public, which determines its value. Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.'[34]

6.24 The Review Team therefore considered the range of data collated by the Trust, how it was analysed, and how it was used by the Trust to monitor and review performance with particular reference to MAH.

[34] The report of the Independent Inquiry into the issues raised by Paterson, Page 2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

6.25 The Trust had a number of systems in place to record and monitor adverse incidents, serious adverse incidents, and complaints as part of its risk management strategy. Risk management involves the establishment of systems to understand, monitor, and minimise risks to patients and staff. It involves learning from mistakes/incidents in order to improve the quality of patient care and to inform staffing numbers and qualifications to ensure that patients' needs are met. It is apparent that Governance and Core Group meetings at MAH regularly had access to a wide range of data (see Para 6.83).

6.26 MAH was also monitored by its regulator, the RQIA, which over the course of its inspections, collated significant information on practice within wards and also acquired verbal feedback from patients and staff. The scale of the significant concerns revealed by the CCTV footage (2017) or the Ennis investigation (2012/13) was not identified through inspections. Regulators, such as senior managers, rely on the information provided to them as well as what they can reasonably be expected to identify in the course of inspection activities.

6.27 A relevant backdrop to how information was divulged is provided by the *A Way to Go* report. It noted that it, 'was advised of the presence of staff who are related at the Hospital, including families who have worked there for generations. Also, since some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to conflict of interest declarations in any file.'[35]

6.28 Learning from mistakes or near-misses requires staff to be open to a review of their practice and to be willing to challenge when they observe concerning

[35] Op. Cit Para. 32, Page 13

professional practices. From the Ennis Report (2013) and the CCTV footage it is apparent that the challenge function was generally not evident among the staff team. In respect of the Ennis complaints, the verbal and physical abuse of patients was not raised by ward staff but rather staff from a private provider who were working on the ward to prepare a number of patients for discharge to their facility. Similarly, the very significant number of alleged assaults on patients captured on CCTV footage which, to date, has resulted in seven members of staff being reported to the PPS by the PSNI, 59 have been placed on temporary suspension, with a further 47 staff working under supervision. The nature and scale of events were not brought to the Trust's attention by MAH staff.

6.29 The Trust had corporate and clinical/professional arrangements in place. The Review Team concluded however, that the nature of the hospital as somewhat of a place apart from the mainstream of the Trust's hospital services, together with ongoing issues around its future, meant that staff loyalties were with their colleagues rather than the patients or their employer. There is also no indication from the records examined that staff from different professional groups were voicing concerns about the level or the nature of adverse incidents, serious adverse incidents, complaints, or the issues likely to be associated with staffing deficits and limited behavioural supports for patients.

6.30 In conclusion, governance structures were in place at Board and Trust level to enable the Trust to assure itself of the quality of the services it provided at MAH. The next section considers governance specific issues.

Clinical and Professional Governance

6.31 Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish.'[36] It covers activities which help sustain and improve high standards of patient care. Clinical governance is a means of reassuring the public that the care they receive within the health and social care system is of the highest standard.

6.32 Clinical governance is often thought of in terms of the following seven constructs:

6.33 The British Medical Journal definition of clinical governance: 'In short, it's doing the right thing, at the right time, by the right person - the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. But that's not all - that individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes.'[37]

[36] Scally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal 317(7150) 4 July pp.61-65
[37] BMJ 2005;330:s254 https://www.bmj.com/content/330/7506/s254.3

6.34 As noted in Para. 6.6 the Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland. Clinical governance is a means by which the duty of quality can be achieved for service users of health and social care services in Northern Ireland. Clinical governance 'aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided (in terms of outcomes, access and appropriateness.'[38]

6.35 In 2012, The King's Fund set out three lines of defence 'in the battle against serious quality failures in healthcare:'[39]

- frontline professionals, both clinical and managerial, who deal directly with patients, carers, and the public and are responsible for their own professional conduct and continued competence and for the quality of the care that they provide;
- the Boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations who are ultimately accountable when things go wrong; and
- the structure and systems that are external, usually at a national level, for assuring the public about the quality of care.

6.36 The legislative framework within which the health and social care structures operates is the Health and Social Care (Reform) Act (Northern Ireland) 2009. The roles and functions of the various health and social care bodies and the systems that govern their relationship with each other and the Department, alongside the

[38] Clinical Governance in the UK NHS. DFID Health System Resource Centre https://assets.publishing.service.gov.uk/media/57a08d59ed915d622c001935/Clinical-governance-in-the-UK-NHS.pdf
[39] The King's Fund (2012), Preparing for the Francis report: How to assure quality in the NHS, [online], accessed September 2019. https://1vju531mjrgz2givvt3vgvrr-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/MPAF_WEB.pdf

roles and responsibilities devolved from the Department, which are taken forward on behalf of the Department by the PHA/HSCB are set out in the Health and Social Care Assurance Framework (2011).

6.37 Service Frameworks set out the standards of care that individuals, their carers, and wider family can expect to receive from the HSC system. The standards set out in a service framework reflect the agreed way of providing care by providing a common understanding of what HSC providers and users can expect to provide and receive.

6.38 The Belfast Trust's Assurance Framework sets out the roles and responsibilities of the Executive Team in ensuring that effective governance arrangements are in place within their areas of responsibility. Key elements of professional, clinical, and social care governance are identified within the roles of the:

- **Executive Director of Nursing and User Experience** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;

- **Director of Social Work** who is responsible for ensuring the effective discharge of statutory functions across all social care services; reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce;

- **Medical Director** who is responsible for advising the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice, and medical workforce requirements. The post holder is also responsible for ensuring that the Trust discharges its delegated statutory medical functions, alongside providing professional leadership and direction.

6.39 There is also a service framework pertinent to the services provided at MAH which applies to all those working with patients namely, the Service Framework for Learning Disability published in 2013 and revised in 2015. 'This Framework aims to improve the health and wellbeing of people with a learning disability, 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.'[40]

6.40 Professional Governance Frameworks are underpinned by legislation and a range of standards and policies set by the Department of Health alongside standards set by professional regulators. A robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across the professions.

6.41 Since its formation in 2007 the Belfast Trust has had in place a structure to support the Executive Directors of Nursing, Social Work, and Medicine to provide assurance to the Chief Executive, Executive Management Team, and the Trust Board. Muckamore Abbey Hospital is medically led by a Clinical Director. The largest workforce on site is drawn from the nursing profession and healthcare assistants. There was a small social work team and a number of Allied Health

[40] Ministerial Foreword, Service Framework for Learning Disability, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-learning-disability-full-document.pdf

Professionals based at the hospital. Although MAH is a hospital and is led as such by medical personnel, the day-to-day operation of MAH was in practice left to nurse managers and their staff. The following section therefore focuses strongly on the governance arrangements within nursing, which also encompasses healthcare assistants (see Para 6.38).

6.42 The Review Team examined the systems and information established by the Belfast Trust to enable it to ensure that patients in MAH were receiving high quality, safe, and effective care. The Trust organisational structure in 2012/13 comprised a Central Nursing and Midwifery Team which was led by the Executive Director of Nursing comprised Co-Directors and Associate Directors of Nursing. The Co-Directors were full time members of the Central Nursing and Midwifery Team fulfilling a pan-Trust professional role in respect of the nursing and midwifery workforce, nursing education, and governance. The Associate Directors of Nursing held managerial roles within the Directorates of the Trust. It was envisaged that they would dedicate 70% of their time to their Directorate role and 30% to their professional role as Associate Directors of Nursing.

6.43 This structure remained in place until 2016/17 when it changed following a review by the HSC Leadership Centre, commissioned to assess the effectiveness of the Associate Director role in providing professional assurance to the Executive Director Nursing. It introduced Divisional Nurses who had no operational responsibilities. They were appointed into leadership roles to provide nursing and midwifery assurance to the Directorate and Executive Director of Nursing.

6.44 The Executive Director of Nursing met formally on a monthly basis with Co-Directors and senior nurse leaders. The meeting provided regular reports from Divisional Nurses on nursing and midwifery practice, workforce issues, regulation, and any other issues of concern. Since 2016 reports focused on three key areas namely:

- patient, quality and safety;
- patient experience; and
- professional nursing.

Nurses in Difficulty meetings were held quarterly and were chaired by the Executive Director of Nursing. These meetings were attended by Divisional Nurses and provided an opportunity for the Executive Director of Nursing to discuss, advise, and seek assurance that all follow-up actions to ensure onward referral to the regulator or internal capability processes had been taken forward.

6.45 Directors of Nursing, according to A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery (2010-2015), were required to be proactive in identifying future nursing workforce requirements. The Executive Director of Nursing in a Trust is also responsible for advising the Trust Board and its Chief Executive on all issues relating to nursing workforce requirements. On a bi-monthly basis the Executive Director of Nursing held a Nursing and Midwifery Workforce Steering Group. This group comprised senior nurse leaders, the Co-Director for Workforce and Education, and a representative from HR, Finance, and staff-side organisations. This meeting addressed all workforce issues relating to nursing and produced a workforce trends analysis.

6.46 In addition to the Workforce Steering Group meetings, the Trust had processes in place to provide assurance to the Executive Director of Nursing on all issues relating to the nursing workforce requirements in MAH. Learning Disability Nursing workforce issues were discussed regularly at the senior nurse meetings which were held on a monthly basis in MAH and at the Core Group meetings chaired by the Co-Director for Learning Disability services. Discussion also took place at Divisional Nurse meetings chaired by the Executive Director of Nursing.

6.47 During the period under review, professional nursing governance arrangements existed within MAH, as indicated by the previously noted senior nurse meetings, which took place on a monthly basis. Those in attendance included senior nurse managers, ward managers, and the nurse development lead. Additionally, there was a Professional Senior Nurse Forum. These meetings were chaired by the Service Manager for Hospital Services and included senior managers from MAH and the Directorate along with the Nurse Development Lead. The agenda for these meetings focused on nurse-sensitive indicators including supervision, appraisal, and mentorship along with training, education, and staff development.

6.48 The Nursing and Midwifery Council (NMC) sets the standards of practice and behaviour applicable to all registered nurses. These standards are outlined in the Code (2015).[41] They are a means to promote safe and effective practice.

6.49 The commitment to professional standards is fundamental to nursing and reinforces professionalism. As such all nurses and healthcare assistants in MAH are required to:

- prioritise people;
- practice effectively;
- preserve safety; and
- promote professionalism and trust.

6.50 The NMC Code established a common standard of practice for all those on its register. Guidance to nurses was also provided by the Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) as professionally they continued to be accountable for the tasks delegated by them to healthcare assistants. Nurses are required to ensure that delegated tasks are completed to a

[41] The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associated, NMC, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

satisfactory standard.[42] The framework supports the healthcare staff in becoming competent to complete delegated record keeping on the care they have provided and maintaining these records.

6.51 Standards for Nursing Assistants employed by HSC Trusts published by the Department In February 2018 apply to all healthcare assistants. This document recognised that nursing assistants 'are an essential part of the healthcare team. They provide a vital role supporting the registered nursing workforce to deliver high quality nursing care.'[43] In MAH it was apparent that at times healthcare assistants made up a greater proportion of staff on wards due to the difficulties experienced in recruiting and maintaining an adequate number of nursing staff. This matter is discussed further in paragraph 6.96.

6.52 The Trust collated and analysed a range of information as a means to identify nursing concerns. The Review Team considered the Trust's wide range of information, along with the minutes of professional and operational management meetings. The key sources of information were:

- Professional Governance Frameworks;
- RQIA Inspection findings;
- Nurses in Difficulty reports;
- Risk Registers;
- Vulnerable Adult reporting;
- Use of Physical Intervention;
- Quality Improvement Plans;
- Key Performance Indicators;

[42] Support Resources for Record Keeping Practice Framework for Nursing Assistants. NIPEC https://nipec.hscni.net/download/projects/previous_work/highstandards_practice/record_keeping_practice_framework_for_nursing-Assistants/SUPPORT-RESOURCE-NA-Framework-Final.pdf
[43] Standards for Nursing Assistants employed by HSC Trusts. Foreword, https://nipec.hscni.net/download/professional_information/resource_section/nursing_assistants/standards-for-nursing-assistants.pdf

- Commissioned Education;
- Staff absence management and recruitment;
- Professional Nursing Reports; and
- Alerts or issues for escalation.

6.53 Since its formation in 2007 the Trust's Model of Governance has been an integrated approach where clinical and wider organisational risks are managed within a single integrated Assurance Framework. Key elements of clinical governance include:

- clinical audit and research;
- incident reporting;
- education and training;
- supervision and appraisal; and
- the adoption of evidence-based practice to ensure safe and effective care.

Arrangements are also in place within the Trust for the management of professional concerns about nurses and midwives. Issues relating to healthcare assistants were dealt with through line management arrangements.

6.54 Capacity for the integration of professional governance into the Directorate's governance arrangements was evidenced in the regular multidisciplinary meetings convened by the Trust's Co-Director who had a social work background and comprised the Clinical Medical Director, the Nursing Service Manager, and the Service Improvement and Governance manager at MAH. Attendance by other professionals or Operational Managers was dictated by the agenda for each meeting.

6.55 The nursing governance arrangements within the Trust were deemed fit for purpose by the Review Team on its examination of processes and the information

detailed above. The Review Team was however concerned that the effectiveness of these governance arrangements was undermined by ongoing staffing issues at MAH.

6.56 Professional Accountability for medicine arrangements were outlined as follows:

'All substantive doctors including consultants are accountable via the line management structure. That is to the Service Manager/Co-Director. Professionally they are accountable via the medical line management structure which is Clinical Lead to Clinical Director to Associate Medical Director to Medical Director. Where concerns are raised about medical staff these concerns are shared by the Clinical Director with the Associate Medical Director and are managed using Maintaining High Professional Standards Guidance, a framework set out by the Department of Health in 2003. Where appropriate the Trust will also invoke the services of the National Clinical Assessment Service.'

6.57 The Review Team had no access to medical workforce data. A review of senior staff meetings referenced however, a range of the workforce issues faced by the medical team on site. Between 2012 and 2016, minutes of the Core Group meetings highlight issues regarding the medical team's ability and capacity to provide 24-hour cover at the hospital. There were efforts over an extended period of time to commission GP services and a GP out-of-hours service. Concerns were also noted about the ability of on-call doctors to complete the admission criteria assessment. A GP out-of-hour service was commissioned in November 2013.

6.58 Consultant medical staff shortages were also evident and were raised frequently by the Clinical Director at Core Group meetings. The management of sickness absence among medical staff was also difficult. Records indicate that locum cover was hard to secure.

6.59 In July 2103 the Clinical Director wrote to the HSC Board to secure additional consultant sessions. The resettlement assessment process placed additional demands on medical staff and the Review Team noted ongoing concerns expressed by the Clinical Director about patient safety resulting from the mix of patients on some wards and the consequent demands placed upon medical staff.

6.60 Nursing staff advised of some difficulties in securing timely access to medical review once an episode of seclusion was activated. There were also difficulties in securing Multidisciplinary Team (MDT) input into comprehensive risk assessments.

6.61 In respect of social work since 1994 Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards[44]. Arrangements for professional oversight are designed to ensure that statutory functions are discharged[45] in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions in respect of:

- child care;
- mental health services;
- disability services,
- community care; and
- the social work and social care workforce.

[44] Health and Personal Social Services (Northern Ireland) Order, 1994
[45] Para. 1.2 CIRCULAR (OSS) 3/2015: 'Relevant' statutory functions, include all functions under the Adoption (NI) Order 1987; the Disabled Persons (NI) Act 1989; the Children (Northern Ireland) Order 1995 (with the exception of the Children's Services Plan) and the Carers and Direct Payments Act (NI) 2002. Other relevant functions are specified under the Health and Personal Social Services (Northern Ireland) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978 and the Mental Health (NI) Order 1986.

6.62 Executive Directors of Social Work have a number of specific areas of professional responsibility including:

- professional governance;
- standards and practice across all services for children, families and adults;
- development of the social work workforce;
- management and/or development of social work and social care services generally; and
- oversight of statutory functions discharged by the HSC Trust.

6.63 In addition to the aforementioned areas of professional responsibility, social workers also have a role in the general management of the HSC Trust, including sharing in corporate responsibility for policy making, decision making, and the development of the HSC Trust's aims and objectives.

6.64 HSC Trusts are accountable to the DoH through the HSC Board for their performance which includes accountability for the discharge of delegated statutory functions. Schemes of Delegation of Statutory Functions[46], which are documents sealed by the Department, the HSC Board, and each HSC Trust, provide a specific legal mechanism to monitor and report on the discharge of statutory functions on an annual basis. The Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the HSC Board to the Chief Social Services Officer (CSSO) and ultimately to the Health Minister.

6.65 Paragraph 3.1 of Circular (OSS) 4.15 clarifies that: 'Accountability is a key element in the discharge of Delegated Statutory Functions (DSF). The Department, as the parent sponsor body of the HSCB and Trusts, carries ultimate responsibility for the

[46] CIRCULAR (OSS) 4/2015: Statutory Functions – Professional Oversight

performance of these organisations, including the discharge of DSFs within a system of delegation. This responsibility is not transferable to any other body.' Paragraph 3.2 also notes that, 'responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs [Arms Length Bodies].'

6.66 All social care workers and professional social workers receive supervision within the organisation. A Supervision Policy exists to inform practice. In unidisciplinary teams, professional social work supervision must be provided by professionally qualified senior social workers, ensuring opportunity to review an individual's professional practice and accountability for the standard of his/her practice. Within integrated teams social workers received monthly supervision from their line managers. Where the manager was not a social worker, professional supervision was required from a social work manager on a three-monthly basis. Both managers were required to meet with the social worker to discuss operational and professional practice on a bi-annual basis. The Review Team was advised that audits relating to social work supervision were conducted. The audits did not confirm compliance with all aspects of the supervision policy, particularly in relation to the bi-annual meetings with managers.

6.67 Audits were also conducted at MAH which were independently commissioned by the Trust.[47] In respect of the deprivation of patients' liberty this report found: 'It is a major concern that aspects of the 'key evidence base' used to underpin these policies were out of date when the policy was written; e.g. NMC and NICE Guidelines.' The audit found that the Seclusion policy 'should have been reviewed in November 2016 and this was not completed.' The Review Team noted that the draft DHSSPS guidance on Restraint and Seclusion had not been used to inform

[47] Cannon F. & Barr O, Report of Independent Assurance Team Muckamore Abbey Hospital, June 2018

Trust policies in these areas.[48] The Review Team noted that the Southern HSC Trust had used the draft guidance to inform its policy. The DHSSPS draft guidance contained helpful advice on: patients' rights; training; and monitoring. It is unfortunate that final guidance was not provided by the Department.

6.68 Arrangements were in place to promote social work practice across client groups. The Executive Director of Social Work chaired the Trust's Adult Safeguarding committee which was established in 2015, although managerially he did not have responsibility for this client group until June 2016 when the Trust as a cost improvement measure removed a number of senior management posts at headquarters and MAH levels.

6.69 The Adult Safeguarding committee was modelled on child protection arrangements which were well established within the Trust and provided a model for improving safeguarding arrangements for vulnerable adults. A Professional Social Work Forum was also in place within the Trust prior to 2012. Managers at Grade 8B and above, attended by the Trust's social work governance lead, chaired the forum which addressed professional development and performance across the Trust. The 8B staff member with responsibility for social work services at MAH also attended the Professional Forum. The Trust's Safeguarding Specialist attended this Forum, at times, to provide updates on adult safeguarding issues.

6.70 There was an unbroken professional line from the frontline social worker to the Trust's Executive Director of Social Work as required legislatively. There were however, insufficient numbers of social workers at MAH to provide a service to all wards or to have the time to visit the wards regularly thereby acquiring an overview of patient care and treatment.

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[48] Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005

6.71 The Review Team was informed that there was a picture of the safeguarding social worker and contact details on ward notice boards so that patients and family members would have had details of a contact point should they have concerns. The Executive Director of Social Worker also outlined a number of walk-around visits he made to MAH during his period in post (from June 2016 to August 2017), during which he met with staff and patients. He acknowledged that from these visits he was conscious of tensions in managerial relationships within the hospital, unease about its future, and low staff morale. He stated that he had no indication of the patient care issues which subsequently emerged once CCTV footage came to light.

iii. The Effectiveness of Corporate and Clinical/Professional Governance

6.72 The Trust identified delivering safe, high quality care as a key priority. It measured and collected a wide range of data as a means of learning from and improving outcomes and experience for service users. To consider effectiveness of professional governance the following section considers:

a. audit;
b. KPIs;
c. discharge of statutory functions;
d. workforce planning;
e. education training and continuing professional development; and
f. overview.

a. Audit

6.73 During the period covered by the Review, 2012 - 2017, the Trust held bi-monthly Mental Health and Learning Disability Audit meetings. It was intended that the agenda for these meetings would be informed by two audit forums, one representing Learning Disability, the other Mental Health. From 2012 to 2015 a total of 14 audits were completed:

- six audits - led by medical staff;
- five audits - led by an Occupational Therapists;
- one audit - led by a forensic Psychologist;
- one audit - led by a safeguarding officer who was a social worker; and
- one audit - led by a resource nurse.

6.74 Audit activity undertaken by nursing staff outside the formal clinical audit cycle was not noted in minutes of professional nursing meetings but referenced in RQIA reports. These audits are inclusive of Nursing Care Plans, risk assessments, and behaviour support plans.

6.75 Minutes from the Audit meetings show that they were poorly attended, and that Mental Health dominated audit topics. Staff representing Learning Disability services frequently acknowledged difficulty in engaging staff to gather data. Completed audits often failed to produce Action Plans capable of providing future measurements to demonstrate improvement and impact over time. During 2014 the Audit Forum for Learning Disability was stood down due to poor attendance and engagement. It subsequently merged into a single forum with Mental Health.

6.76 At a subsequent Governance meeting chaired by the Co-Director for Learning Disability, it was acknowledged that the lack of engagement and the failure to

contribute to the prioritisation of audit topics was a missed opportunity to address areas of concern within learning disability services.

b. KPIs

6.77 Key Performance Indicators (KPIs) are measurable indicators that demonstrate progress towards a specific target. They are essential in order to drive improvements in safety, efficiency, quality, and effectiveness as well as evaluating performance. During the period under review there were a number of KPIs against which nursing care at MAH was monitored. These were corporate KPIs used across all care settings. There were no person-centred or care specific KPIs for inpatient learning disability services. Additional performance indicators were identified by learning disability staff. These included nursing supervision, appraisal, mandatory training, and workforce.

6.78 The Trust also used NICE Guideline (NG11)[49] which were published and endorsed by the Department of Health in 2015. NICE guidelines are accepted as best practice. These guidelines cover interventions and support for adults with a learning disability and behaviour that challenges.

6.79 Workforce Steering Group minutes indicate that in 2015, MAH was progressing through The Quality Network National Peer Review. This is a standards-based quality network that facilitates the sharing of good practice. At the same time efforts were being made to introduce ward-based outcome measurement tools.

6.80 In January 2016 there was an agreement between senior nursing staff that the hospital should sign up to the Restraint Reduction Network[50]. The Network exists to support organisations to reduce reliance on restrictive practices.

[49] https://www.nice.org.uk/guidance/ng11
[50] Restraint Reduction Network @THERRNETWORK

6.81 During the period under review the Trust achieved a high rate of compliance with the Corporate Nursing KPIs. This is reported in the annual report of the Director of Nursing on the Key Challenges and Achievements which are reported to the Trust Board on an annual basis.

6.82 The Standards for supervision in nursing were met with exceptions recorded for some Bank and Agency staff. These reports were presented annually to the Trust Board and sent to the Chief Nursing Officer.

6.83 Data pertaining to vulnerable adults, physical intervention, restraint, and seclusion was collected and discussed generally on a fortnightly basis at Governance and Core Group meetings. There was no evidence of an analysis of the data or the production of trend data. At times it was noted that staffing levels, the admission of a new patient, or ward changes impacted upon the number of incidents recorded. There was no evidence that the information collated was used in a proactive manner to address factors known to relate to challenging behaviours on wards. There was also no reference to measurement of compliance with the NICE Guidelines in the documentation provided to the Review Team. The failure to use information to affect changes in practice led, in the opinion of the Review Team, to the over-use and misuse of physical intervention, restraint, and seclusion as found in the *A Way to Go* report (November 2018).

6.84 Regular audits of Nursing Care Plans, Risk Assessments, and Behaviour Support were not discussed at professional or operational meetings. Those topics were however, subsequently introduced into these meetings as part of findings emerging from RQIA inspections. Routine audit findings were not evident in any of the documentation examined by the Review Team.

6.85 The *A Way to Go* Report considered 61 RQIA reports and found that, ‘the RQIA inspection reports and Patient experience interviews do not provide a single

overview of Muckamore Abbey Hospital. They present dispersed and sequential information about individual wards and the observations of some patients.' It further noted that, 'it is difficult to draw conclusions from 61 narrative texts and hundreds of recommendations, the process would reveal more about repeated recommendations than in understanding the Hospital as a whole, its contexts and the explanatory frameworks of involved parties than about ways of abating or controlling abuse and harm.'[51] RQIA reports, audit reports, and an ongoing analysis of the range of data collected by the Trust provided professional leads with the opportunities to work preventatively rather than reactively to events at MAH. One manager described to the Review Team 'a sensation of always fire fighting' at MAH.

6.86 Senior nursing staff advised the Review Team that Care Plans were often incomplete and activity records at various times were poor. From the documentation available to the Review Team it was unclear whether the Quality Network National Peer Review initiative was pursued to completion (see Para 6.75).

6.87 Membership of the Restraint Reduction Network was to be discussed at the Core Meeting in Feb 2016. The Review Team found no reference to this discussion or that membership was ever taken up. It is clear however, from the *A Way to Go* report that in 2018 restraint, physical interventions, and seclusions were still being used extensively. It commented: 'Three other [RQIA] reports noted the marked absence of an agreed, consistent, proactive behavioural management strategy…physical environment not conducive to the patients' needs, particularly concerning noise levels…the importance of developing and implementing a system of governance to ensure that incidents that result in the use of physical intervention, seclusion or PRN administration are comprehensively reviewed.' [52] References to boredom, the environment, and/or the absence of proactive

[51] A Way to Go, December 2018, par. 7 - 8, Pages 7 - 8
[52] Ibid, Para. 95, Page 29

behavioural support strategies were regularly noted when incident data were reviewed. Yet the information did not inform revised ways of working with patients with complex and/or challenging needs.

c. Statutory Functions Reporting

6.88 The Review Team reviewed the Trust's Discharge of Statutory Functions (DSF) Reports from 2012 to 2017. The legal significance of these reports has been set out in paragraphs 6.58 and 6.59. The reports were largely repetitive and gave little sense of the extent of compliance with statutory functions. A Safeguarding Report was provided separately from the Discharge of Statutory Functions Reports. Despite repeated requests the Review Team did not receive copies of these associated reports.

6.89 The DSF Reports gave no specific details about how statutory duties under the Mental Health Order 1986 were discharged. Article 121 of the Order addresses the ill-treatment of patients.[53] The Review Team considered the absence of information on DSF Reports providing assurances on the treatment of patients to be an omission. The DSF Reports did not report to the HSC Board on the Ennis Report, on its conclusions, or how recommendations were being taken forward. The 2014 DSF report did not report on approval for the installation of CCTV at three wards in MAH to improve safeguarding arrangements. Neither was the subsequent installation of CCTV during July 2015 reported.

[53] Mental Health Order 1986, *Ill-treatment of patients*

121.—(1) Any person who, being an officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or being a member of the[F1 Board or a director of the [F2HSC trust] managing] a hospital, or a person carrying on a private hospital or nursing home —

(a)ill-treats or wilfully neglects a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or nursing home; or

(b)ill-treats or wilfully neglects, on the premises of which the hospital or nursing home forms part, a patient for the time being receiving such treatment there as an out-patient,

shall be guilty of an offence.

6.90 The Review Team was informed that during the period of its review there had been discussion about altering the structure of the DSF Reports due to their repetitiveness. The view then was that the DSF Reports needed in the future to be a more outcome-focused reporting system. In the absence of a new DSF structure, reporting continued to lack specificity.

6.91 The HSC Board met annually with Belfast HSC Trust to review its DSF report. The Review Team had access to extracts of reports from the HSC Board to the Trust. Comments regarding MAH related to missing resettlement targets. The emphasis on resettlement is a recurrent theme in the management of MAH, at times to the detriment of the core hospital and the quality of patient care (see Para 5.21). There was no information in DSF Reports regarding the uncertainty about the hospital's future which was causing problems in staff recruitment and retention. The associated issues surrounding the use of bank and agency staff and the implications for the quality and continuity of care for patients was not evident in DSF reports.

6.92 As currently structured and reported upon, the DSF Reports examined by the Review Team did not provide sufficient assurances about the discharge of statutory functions as they related to learning disabled patients.

d. Workforce Planning

6.93 From the Review Team's examination of minutes and discussions with senior nursing staff it is evident that nursing staff shortages were directly impacting on the hospital's ability to provide safe and effective care. In March 2012 this was deemed to be a red risk and was added to the hospitals risk register. Minutes of the monthly Senior Nurse meetings held in 2012 - 2017 make frequent reference to:

- staffing at crisis level;
- staff working excessive hours;
- high reliance on bank and agency staff;
- qualified staff not being in place;
- high levels of sickness absences;
- poor staff morale;
- high levels of staff turnover;
- early ward closures designed to relieve staffing pressures;
- staffing deficits recorded on the Datix information system;
- day care activities restricted for patients to maintain safe staffing levels on wards; and
- the increase of adult safeguarding incidents which was attributed to staff shortages.

6.94 RQIA inspection reports also reported on staff shortages and resulted in a number of whistle-blowing concerns being raised with RQIA during the period under review. The Review Team did not have access to workforce plans or documentation identifying safe or minimum staffing levels and associated skill mix ratios for years 2012 - 2017. Senior nursing staff did report the use of the Telford assessment tool but recognised that this did not take into account the complexity and acuity of patient needs. Nonetheless there is no evidence in any of the documentation reviewed of any systematically applied objective assessment of staffing needs across the hospital. The *A Way to Go* Report also noted that 'the appropriate complement of staff for the wards remains unclear.'

6.95 Short term workforce planning resulted in the recruitment of staff on temporary contracts, reflecting the assumption that the required staffing establishment would be exceeded post resettlement. This strategy was in place from 2012-2016. This approach to staffing resulted in high levels of staff turnover and recruitment difficulties. A competitive recruitment market to establish a new community

infrastructure further compounded the downward trend in staff retention. This was matched with the absence of a career development framework. This resulted in Learning Disability Nurses leaving the service to train as Health Visitors.

6.96 Failures in recruitment resulted in changes to skill mix on wards. The Director of Nursing advised the Review Team that she believed the skill mix at its lowest was 40:60. The Service Manager advised the Review Team that on some wards the skill mix was as low as 20:80 making it difficult to ensure that there was more than one registrant on the ward at any given time. The Review Team noted that healthcare assistants rather than nurses dominated staffing on some wards. The Review Team considered this ratio to be material in determining the quality of professional oversight available over the 24/7 work roster.

6.97 The Review Team was advised by the Director of Nursing that she was not assured that the staffing ratios were sufficient to provide safe and effective care. She issued a directive stating the need for a minimum of at least two registrants per shift. When interviewed she advised the Review Team that she believed current ratios and the skill mix were not an accurate reflection of the acuity of the remaining patients. This will undoubtedly result in poorer outcomes for patients and inhibit nursing innovation and improvement. The Review Team noted that the Director of Nursing was not the financial budget holder for the nursing workforce.

6.98 Throughout the period under review there was clear evidence of recurrent recruitment drives for staff at MAH. The regional challenges associated with recruiting Registered Learning Disability Nurses was noted by the Review Team. The Trust's investment in supporting staff to undertake the Specialist Practitioner programme was also noted. The staffing crisis meant that those specialist staff were needed to meet the core staffing needs of the wards. Their skills and expertise were not therefore available to use in developing and supporting person-centred nurse developments.

6.99 The uptake of training was also adversely affected by staffing shortages. During a 2017 Listening Exercise the Trust found 'cancelled training sessions resulting in poor compliance with mandatory training updates.' The Review Team considered that the high vacancy and turnover rates also impacted upon the Trust's ability to develop staff to meet new and emerging best practice developments.

6.100 An examination of correspondence between the ward Sister of Ennis and her line manager confirmed that on a number of occasions the level of staff available on the ward and their skill set was, in her opinion, inadequate to meet the needs of patients or to progress the resettlement agenda. The issue of staffing numbers had been placed on the Learning Disability Services' Risk Register during the Spring/Summer of 2012 as a high risk. Yet this risk was not placed on the Trust's Corporate Risk Register as per the Trust's policy.

6.101 Immediately after the Ennis complaint (November 2012) came to light the Executive Director of Nursing asked a Co- Director of Nursing with a Trust-wide remit for nursing workforce and education to work in support of the Service Manager and to provide assurance to its Executive Team on the Ennis Investigation. This staff member had regular supervision with the Director of Nursing throughout this deployment. An assessment of nursing within the Ennis Ward was undertaken. This assessment identified a number of shortcomings around matters which included:

- staff induction;
- the student learning environment;
- staffing;
- care planning; and
- monitoring.

A number of improvements were put in place which included enhanced staffing, staff appraisal, and training while remedial action was taken to improve the ward environment.

6.102 While there was an agreed formula (The Telford Formula) to determine staffing levels in learning disability hospitals, it is evident from documentation considered by the MAH Review Team that there were ongoing issues relating to the adequacy of staffing numbers and qualifications. CCTV footage showed patients being harmed by staff in the Psychiatric Intensive Care Unit (PICU), which had the highest staffing levels and ratios of qualified staff. Yet no safeguarding referrals were made and no members of staff spoke out.[54] There is therefore no straightforward linkage between staffing levels and abuse. That being said, over-stretched and tired staff are more likely to be less resilient when dealing with patients with complex and/or challenging needs.

6.103 Inspection reports from RQIA and minutes of senior staff meetings confirmed that the hospital was operating without the full range or availability of a multidisciplinary team (MDT). In 2012 it was reported that the hospital had:

- no Occupational Therapists;
- only 1.5 whole time equivalent (WTE) Speech and Language Therapists based in Day Care;
- 0.5 WTE Dietician,
- one psychologist;
- two WTE Physiotherapists, which was subsequently reduced to 1.5 WTE to meet cost improvement targets.

In addition there were three social workers and a small number of behaviour support nurses or assistants.

[54] Op. Cit. par. 4, Page 4

6.104 Senior staff advised the Review Team that much of the focus of the MDT was directed to the resettlement wards. Psychology input was evident in PICU but efforts to secure funding to extend psychology services across the hospital were unsuccessful. The Review Team found that restricted access to psychology had a detrimental effect on the ability to develop, educate, and support nursing staff to deliver therapeutic interventions. The Review Team acknowledged the role of the Behaviour Support Service but noted that staff and RQIA both reported inconsistent availability of these staff, evidenced by patients' behaviour management plans which were poorly documented.

6.105 Minutes of senior nurse managers meetings recorded difficulties in accessing MDT input into comprehensive risk assessment.

e. Education Training and Continuing Professional Development

6.106 The Trust has committed to building the capacity of its workforce through education, learning, and development with a range of clinical and leadership opportunities.[55] An integral part of good governance is education, training, and continuing professional development activities for staff. These are also essential in enabling the Belfast HSC Trust to achieve its objective to deliver safe and effective care. Access to continuing professional development and leadership opportunities support the Trust's ambition to become a leader in providing high quality care through a relentless focus on quality improvement.

6.107 The Trust has in place structures and processes to support education training and induction for all staff including Health Care Assistants (HCAs). These are translated into functions within the HR Directorate and embedded in professional

[55] https://belfasttrust.hscni.net/working-for-us/staff-development/

assurance structures. These structures include a Co-Director of Nursing for Education and Learning who is a member of the Central Nursing and Midwifery Team along with a senior nurse for Nursing Research and Development. Similar arrangements are in place for the medical profession where a Deputy Medical Director is employed with responsibility for education and workforce issues.

6.108 For social work the Trust employed a governance specialist at Director level with responsibility for the professional development of social workers and for wider governance assurances and policy developments in respect of social work and social care issues. By chairing a Professional Forum of social work managers at Level 8B and above, the Executive Director of Social Work was able to promote consistency of professional social work practice across all Directorates. This also provided an opportunity for updates on professional practice by, for example, input from the Trust's safeguarding specialist.

6.109 Professional regulators, such as the NMC, the General Medical Council (GMC), and the Northern Ireland Social Care Council (NISCC) also require Continuous Professional Development of their registrants. Professional development in the Trust must be offered to comply with such requirements. A wide range of Education Programmes and learning opportunities are available to staff which are accessed through Queen's University Belfast, the Ulster University, the Open University, and a range of other providers such as the Royal Colleges, the Clinical Education Centre, and the Leadership Centre.

6.110 Service led education commissioning for nurses in the Trust is translated into a learning needs analysis. This needs analysis is informed by:

- individual review/appraisal;
- incidents and accidents;
- service developments; and

- professional developments and complaints.

6.111 Additionally, education delivered by the Clinical Education Centre was also available to staff under a Service Level Agreement with the Trust. This education was provided under the auspices of full or half-day programmes, short courses, or bespoke education at the request of the Trust.

6.112 The Belfast Trust has a long history of promoting and supporting Practice Development as a means of changing and improving practice. Much of this work is undertaken in partnership with the Ulster University. It is widely published and is recognised on an international level. Practice Development is seen as a complex intervention and one that embraces attitudinal and behavioural change. The ultimate purpose of practice development is the development of person-centred culture delivering safe and effective person-centred care.[56]

6.113 Post-Registration Education Commissioning for nursing was a robust process undertaken on an annual basis. It is difficult from the information provided to discern what education was commissioned specific to staff at MAH as records refer only to Learning Disability. Trust records of commissioning requests between 2012 and 2017 include a range of requested programmes:

- the Management of Actual and Potential Physical Aggression (MAPPA) Training;
- Developing Practice in Health Care;
- Principles of Assessing People with Learning Disability and Mental Health problems;
- Contemporary issues in Learning Disability;
- Fundamentals in Forensic Healthcare;
- Specialist Practitioner Learning Disability (2015 and 2016); and

[56] McCance T. & McCormack B. Person Centred Nursing: Theory and Practice, Wiley, 2010

- A range of RCN programmes to support the development of ward managers.

6.114 The number of places requested was small with the exception of MAPPA Training which had approximately 50 places and the Specialist Practitioner Programme which had 12 places and required staff to be released from practice to study full time during the academic year.

6.115 The Review Team commend the commissioning of the Specialist Practitioner programme and MAPPA training. The Review Team noted, however, that little priority was given to therapeutic, evidence-based learning. This is against the backdrop of the 2015 NICE Guidelines and a growing body of evidence to support therapeutic intervention.

6.116 At the beginning of 2016 minutes of a senior nurse managers meeting at MAH reflected discussions and a desire to strengthen positive behaviour support. Reinforce Appropriate, Implode Disruption (RAID) training was discussed and training offered to Band 6, Band 7, and Band 8A staff. The Review Team noted that further training was planned but staffing on the wards remained challenging and psychology support was insufficient because of limited resource. The Review Team noted that the RAID approach like MAPPA is reactive in nature to short term management of violence and aggression and is less relevant to NICE Guideline 11 (NG11) (see Para 6.78) which promotes preventative approaches leading to a reduction in restrictive interventions. Approval of the policy to support the roll-out of the Positive Behaviour Strategy in MAH was not received until October 2017.

6.113 The Review Team further noted that whilst Practice Development was encouraged and supported across other programmes of care, the opportunities for staff in MAH were very limited. The Review Team found no evidence of Practice Development Initiatives other than the Productive Ward/Releasing Time to Care series in 2012.

6.114 Induction Training was predetermined for all staff working in MAH and was essential for the preparation of Health Care Assistants. The review team did not access training records for these staff but noted in 2012 that the Co-Director of Nursing for Education and Workforce reported there was little evidence of adequate induction and staff lacked knowledge of the safeguarding framework. The Service Manager was asked to put in place an appropriate induction plan, which was monitored and reported upon, in subsequent RQIA Inspections. The findings of these inspections confirmed that induction training was available but often compromised because of staffing shortages.

6.115 Mandatory training was also specified for all staff working in MAH. Compliance was monitored by the ward managers and formed part of the appraisal process. It was also reviewed by RQIA during its inspections which found that the uptake of mandatory training was inconsistent across the hospital site. The *A Way to Go* Report supports these findings, as does the Listening Exercise with staff conducted in 2017.

f. Overview

6.116 At corporate and clinical levels the Belfast HSC Trust had in place a range of structures, reporting arrangements, professional managerial systems, risk monitoring, educational and professional development processes, and information systems capable of ensuring good governance at MAH. RQIA in its 2016 Report (Review of Quality Improvement Systems and Processes),[57] noted that the main areas of activity for the Belfast Trust were acute hospital care, community care, and social care. The limited focus on a learning disability hospital was also evident on the Trust's website which was only updated in July 2020 to include MAH as one of the Trust's hospitals.

[57] https://rqia.org.uk/RQIA/files/cc/cc11ffbd-7f69-4605-b637-ab763e049b1e.pdf

6.117 The Review Team in its meetings with senior Trust personnel and MAH staff formed the view that MAH was not only geographically distant from the Trust but was largely 'outside its sightline' as one staff member stated. The review of minutes from Trust Board meetings and Executive Team meetings up until until August 2017 showed that the hospital operated with minimal attention at Trust level.

6.118 The values of the Belfast Trust are:

- working together;
- excellence;
- compassion; and
- openness and honesty.[58]

These values did not pervade the care provided by some staff at MAH to vulnerable adults as evidenced by the Ennis investigation and the events captured on CCTV during 2017. The reasons for such lapses are complex and the Review Team considers it too simplistic to attribute it solely to staffing difficulties when one considers that the events in PICU in 2017 occurred on the ward with the highest staff to patient ratio and a greater number of registrants to healthcare assistants. Similarly, governance arrangements do not adequately answer why problems occurred and went undetected and un-remedied.

6.119 RQIA listed a number of specific drivers to embed a Quality Improvement (QI) culture in MAH which included:

· learning from Serious Adverse Incidents (SAI)

[58] **Working Together - We work together to achieve the best outcome for people we care for and support.**
Excellence - We deliver safe, high quality, compassionate care and support to everyone including you.
Openness and Honesty - We are open and honest with each other and act with integrity and sincerity.
Compassion - We are sensitive, caring, respectful and understanding towards people we care for.
https://belfasttrust.hscni.net/working-for-us/hsc-values/

- the ability to meet Key Performance Indicators
- listening and learning from patient experience and service user feedback
- empowerment and ownership by staff to innovate and improve based on clinical evidence.[59]

6.120 The Review Team saw limited evidence of a learning culture from the minutes it reviewed or of a willingness to interrogate the significant amount of information which was collated regularly and brought to Governance and Core Group meetings at MAH. An Executive Director noted a 'lack of curiosity' amongst senior clinicians at MAH. The fact that MAH information, staffing, or performance were rarely on the agenda for Trust Board or Executive Team meetings showed that a lack of curiosity. Any focus at Trust and HSC Board levels on MAH appeared restricted to resettlement matters and failure to meet these targets.

6.121 In commenting on the closed nature of relationships at MAH the *A Way to Go* Report states that 'some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients.' (see Paras 6.27 and 6.29) This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust.

[59] Op Cit. Review of Quality Improvement Systems and Processes, RQIA, Page 13

Summary Comments and Findings

- **The Trust is one of the largest integrated health and social care organisations in the UK. Its governance structures were complex and appropriate.**

- **The organisational governance structures remained largely consistent between 2012 and 2017. Had they been used appropriately, they had the capacity to alert the Executive Team and Trust Board to matters of concern at MAH.**

- **Complaints about professional practice in Ennis ward in November 2012 were not raised as an SAI or a complaint.**

- **Inspection findings from RQIA were Ward specific. A single overview of the hospital was not provided. RQIA reports resulted in multiple recommendations which were frequently repeated. There was no indication of wider learning or action plans to implement the recommendations from inspection reports. RQIA did not serve Improvement Notices on the Trust in respect of MAH until November 2019.**

- **Clinical audit was dominated by mental health services. Learning disability services were reluctant to engage with audit. This was a missed opportunity to address issues of concern with this directorate.**

- **KPIs were generic rather than specific to inpatient learning disability services and lacked a person-centred focus.**

- **Discharge of Statutory Functions (DSF) Reports were largely repetitive**

narrative documents which provided limited information regarding the discharge of functions under the Mental Health Order 1986. Generally, comments on these reports from the HSC Board related to resettlement targets. There was insufficient challenge at Trust Board, HSC Board, and Departmental levels to ensure DSF Reports were outcome focused.

- **Staffing shortages and the lack of an MDT directly impacted on the provision of safe and effective care.**

- **Wards closed earlier than planned without due regard to the impact on patients or the required skill mix within the staff team. A low ratio of nurses to healthcare assistants was reported. The dominance of healthcare assistants compromised the quality and scope of professional nursing oversight.**

- **Patient activities were curtailed due to staffing shortages which resulted in increased levels of boredom and behavioural challenges with an over reliance on restrictive practices.**

- **Consistent recruitment drives resulted in temporary appointments due to the moratorium on recruitment which was driven by the plan to close large portions of MAH under the resettlement agenda.**

- **The lack of a career development pathway resulted in staff leaving to take up positions in Health Visiting.**

- **The hospital operated without the full range or availability of a multidisciplinary team which reduced the behavioural support available to patients.**

- **The focus on education and training was on mandatory training rather than therapeutic evidenced based learning. The lack of investment in staff training and development meant that challenging behaviours were poorly understood. Staff attendance at mandatory training was also poor because of staff shortages.**

- **A comprehensive range of data was collected on a monthly basis and presented at Governance and Core Group meetings. There was no evidence of analysis or triangulation of this data or its use to inform patient care or staff training.**

- **There was a clash of values between MAH and the Trust.**

7. Review of Leadership

7.1 This section considers leadership in the Belfast Trust at the following levels:

i. leadership requirements for a HSC Trust;
ii. leadership and management arrangements within the Belfast HSC Trust; and
iii. leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels.

i. Leadership Requirements for a HSC Trust

7.2 The Belfast HSC Trust was established in April 2007 as part of the Review of Public Administration (RPA): a major reorganisation of public sector bodies in Northern Ireland. Prior to this reorganisation there were 19 HSC Trusts, with four commissioning HSC Boards providing integrated health and social care services to the population of Northern Ireland on behalf of the Department of Health under the provisions of the Health and Personal and Social Services (Northern Ireland) Order 1972. The RPA resulted in the reconfiguration of the 19 Trusts into six Trusts. The four HSC Boards were replaced by a regional HSC Board.

7.3 When established the Belfast HSC Trust was the largest of the new Trusts with a budget of £1.1billion, employing more than 20,000 staff. Four of the six Trusts which merged to create the Belfast HSC Trust were acute hospital Trusts: the Royal Group of Hospitals, the Belfast City Hospital, the Mater Infirmorum Hospital, and Greenpark Trust. The remaining two Trusts were community health and social care Trusts serving the North and West Belfast and the South and East Belfast

populations of Belfast. Prior to the RPA Muckamore Abbey Hospital had been managed by the North and West Belfast Community Trust.

7.4 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 established the Regulation and Quality Improvement Authority (RQIA) (Article 3). Article 35 of the Order defines the role of RQIA. The legislation also conferred a statutory duty of quality on each health and social care organisation in Northern Ireland (Article 34(1)[60].

7.5 In 2006 the Department published standards[61] (Quality Standards) to support good governance and best practice within the HSC. The five key quality themes within these Standards are:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social wellbeing; and
- effective communication and information.

7.6 In publishing the Standards the Department stated that, 'RQIA in conjunction with HSC organisations, services users and carers, will agree how the standards will be interpreted to assess service quality. Specific tools will be designed to allow the RQIA to measure that quality and assist HSC organisations to assess themselves. RQIA will provide a report on its assessment of governance from 2006-2007 onwards.'

[60] **34.**—(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of —
(a) the health and personal social services which it provides to individuals; and
(b) the environment in which it provides them.
[61] Quality standards for health and social care https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

7.7 The Review Team's remit relates to governance and leadership within the Belfast HSC Trust. In this regard the first quality standard, Corporate Leadership and Accountability, is most relevant to the Review. This standard establishes a number of criteria by which RQIA and HSC organisations can determine the degree to which each organisation complies with it. Relevant criteria when reviewing leadership and determining compliance levels include:

- 'Has a coherent and integrated organisational and governance strategy appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.

- Has structures and processes to review and action its governance arrangements.

- Ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory function and in relation to interagency working.

- Undertakes systematic risk and risk management of all areas of its work.

- Has a workforce strategy in place that that ensures clarity about structure, function and roles and ensures workforce development to meet current and future service needs in line with Department policy and the availability of resources.'

7.8 Section 6 of this report examined the range of governance issues within Belfast HSC Trust relevant to Standard 1 of the Quality Standards, namely: the governance structures; risk management arrangements; assurance in respect of the discharge of statutory functions; and workforce strategy.

ii. Leadership and Management Arrangements in the Belfast HSC Trust

7.9 *The Belfast Way* was published by the Belfast Trust in 2008. It set out a strategic direction for the Trust. Its objective was to offer guidance and motivation to all those involved in serving its resident population. It stated that the Trust would work within government policy to secure the purpose of the Trust which was to improve the health and wellbeing of its population and to reduce health inequalities. *The Belfast Way* had five strategic objectives:

i) Safety and Quality - continuous improvement in the quality of our services and a focus on safety is a priority for all our people, from the Board of Directors to the teams providing care and services.

ii) Modernisation - We believe it is timely to modernise the way we deliver our health and social care. We want to reform and renew our services so that we can deliver care in a faster, more flexible, less bureaucratic and more effective way to our citizens.

iii) Partnerships - working in partnership with individuals and communities leads to more appropriate care and treatment, improved outcomes, better experience by our service users, improved health outcomes and wellbeing for communities and greater social inclusion.

iv) Our People - Our vision is to be seen as an excellent employer within the health and social services family and beyond. Our people will feel valued, recognised and rewarded for their endeavours. They will be supported in their development and their worth as individuals will be respected in the application of their skills in delivering our vision and purpose.

v) Resources - Our financial strategy will ensure that the income we receive from Government provides services which add value, are affordable and set within the organisations overall risk and assurance framework. The organisations duty of care to the public is paramount in all expenditure decisions.'

7.10 These strategic objectives were underpinned by a set of values which include:

- respect;
- dignity;
- accountability;
- openness;
- trust; and
- learning and development.

7.11 In 2009 the Trust set out its approach to leadership in a document titled 'Leadership and Management Strategy 2009-2012'. The Review Team was advised that this strategy document was replaced in 2016 by a Leadership and Management Framework known as 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels.' (see Para 7.25)

7.12 The Leadership and Management Strategy sets out how it supported the Trust's five corporate objectives contained in *The Belfast Way*. It also considered the distinction between leadership and management. It stated that: 'The key purpose of leadership and management is to provide direction, gain commitment, facilitate change, and achieve results through the efficient, creative, and responsible deployment of people and other resources.' It provided definitions of each:

- 'Leadership is an interpersonal relationship and process of influencing, by employing specific behaviours and strategies, the activities of an individual

or organised group towards goal setting and goal achievement in specific situations.

- Management, in contrast refers to the co-ordination and integration of resources through planning, organising, directing and controlling to accomplish specific work related goals and objectives.'

7.13 The strategy included a management and leadership charter. The charter set out the principal actions, knowledge, and guiding behaviours required of leaders and managers in the Belfast Trust and reiterated the values that were set out in *The Belfast Way*, (see Para 7.10). During the period under review (2012 - 2017) the Trust had three different Chief Executives, one of whom served on a part time basis. There was also a six month period during which an Interim Chief Executive was in place pending the appointment of the new Chief Executive. During the review period responsibility for learning disability services also rested with three different Directors.

7.14 In 2007 the Trust Board approved the management structure to provide leadership within the new organisation. Responsibility for MAH was included in the Directorate of Social Work, Children's Community Services, and Adult and Primary Care Services. This was a huge Directorate which accounted for approximately a quarter of the total spend of the Trust. When the Director retired in 2012 the post was split into two with the creation of a Director of Social Care and a Director of Adult and Primary Care. Under each Director were a number of Co-Directors, each of whom had responsibility for a discrete service area. MAH came under the remit of the Co-Director for Mental Health and Learning Disability Services. In addition to the Director with operational responsibility for MAH, the Executive Director of Nursing was responsible for professional matters in respect of nursing.

7.15 The Trust's Executive Team and MAH managerial structures remained in place until the Director of Adult and Primary Care retired in the summer of 2016. At that time the Director of Children's Community Services was asked to lead both Directorates. He was reluctant to do so but agreed to undertake the role for an initial period of six months during which time he would prepare a position paper on the proposed structure. The Review Team was not able to test out the rationale for this proposal with the then Chief Executive. The Review Team had access to the position paper which set out a range of significant shortcomings associated with the conflation of both Directorates. These included:

- The structure had been tried before, prior to 2012, and senior staff in both Directorates felt the portfolio was unworkable;
- It diluted the community voice within the organisation and specifically at Trust Board level;
- It unbalanced the make-up of the Executive Team;
- The job was huge in volume and complexity (comprising a third of the Trust's business area) resulting in the post-holder considering that at times he was 'skimming over issues and information';
- The span of control with 11 direct reports was too great;
- Other Trusts had three persons in post discharging the functions required of the post-holder.

7.16 The Director recommended a return to two Directorates which occurred in the latter part of 2017. In addition to merging the two Directorates in June 2016, the Co-Director Learning and Disability Services post was surrendered when that post-holder retired circa September 2016 as a cash releasing exercise. A Band 8B post at MAH was also surrendered in 2016 on the retirement of the incumbent. The Review Team was advised on the effort taken by the Director of Social Work, Children's Community Services, and Adult and Primary Care Services to secure the re-instatement of both these posts.

7.17 There was no evidence available to the Review Team that having one Director specifically with an Adult and Primary Care remit resulted in MAH being afforded a greater level of attention. The Director did hold a number of meetings on site but according to interviewees, staff at MAH were not aware of who was responsible for the hospital at Executive Team and/or Trust Board levels. The Review Team was told that the decision to surrender the Co-Director Learning Disability Service and the Band 8B posts for cash releasing purposes in 2016 was made by the Director of Adult and Primary Care immediately prior to her retirement without any discussion with staff at MAH or Executive Team colleagues. There is no evidence available relating to how the decision to release staff was made. The incoming Director stated that he spent much of the next year working to have these posts reinstated; an objective which he secured. The Co-Director post was filled during October/November 2016 by MAH's Service Improvement and Governance manager.

7.18 There is no information from Executive or Trust Board minutes of a greater focus being afforded to MAH when the Director Adult and Primary Care was in post from 2012 to 2016. The Review Team had the benefit of interviewing this retired staff member. Although the Ennis investigation took place during 2012/13, the Director of Adult and Primary Care could not recall any engagement she had with the investigation process. She did, however, state that she had read the report. The Report had not been tabled at Executive Team or Trust Board meetings as the Director of Adult and Primary Care considered the matters to have been appropriately addressed. Much of the focus of the Director of Adult and Primary Care related to the resettlement agenda at MAH and the cash releasing targets set by the Department at that time.

7.19 The Executive Director of Nursing was aware of the Ennis investigation. She was aware that approximately £500,000 was provided to fund the 24/7 monitoring on

that ward as a consequence of the investigation. Like the Director of Adult and Primary Care, the Director of Nursing did not bring the Ennis investigation or the subsequent report to the attention of Executive Team colleagues or the Trust Board. The Review Team was concerned that multiple alleged abuses of patients by more than one perpetrator was not considered of significant enough priority to bring it to the attention of the Executive Team or the Trust Board.

7.20 Structural changes at Executive Director level had an impact on the operational oversight and support available to managerial staff based at MAH. The fact that one Executive Director described being uncomfortable about having time only to skim over issues and information (Para 7.15) concerned the Review Team. This Director attempted to be visible at MAH through a series of 'walkabouts' during which he engaged with staff and patients in an effort to identify issues relating to tensions among the hospital's managers which had been brought to his attention. The staff team were reported to have low morale with anxieties about their future given the resettlement agenda and planned closure of wards. His efforts to elicit information directly from staff and/or patients proved unsuccessful. He advised the Review Team that he thought this failure to acquire information was possibly due to staff's lack of trust. The Director of Nursing also advised the Review Team that she made several visits to MAH during the period under review but detected no issues of concern.

7.21 The Review Team found a 'culture clash' at MAH (see Para 8.20). It was also informed of dysfunctional working relationships among the MAH management team. An anonymous letter was sent in January 2017 in respect of the performance of the Service Manager indicating the views expressed were those of a number of staff. This led to a period of supervised practice with support provided by the Co-Director of Nursing for Workforce and Education and the Leadership Centre.

7.22 Documentary evidence confirmed that efforts by the Service Manager to highlight the staffing difficulties through the hospital's risk register created tension between her and the Service Improvement and Governance manager who asked her to downgrade it from a serious to a moderate risk . The Service Manager also provided a SAI to the governance department on 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to meet the criteria (see Para 8.104). The Trust's policy was that red risks at service level should be escalated to its Corporate Risk Register. The reason for this omission in respect of staffing at MAH was, in the view of the Review Team, a failure of the Service Improvement and Governance manager to escalate it appropriately.

7.23 At the end of August 2017 the Director of Social Work, Children's Community Services and Adult and Primary Care Services retired. The post, as per his Position Paper recommendation, was split again into two Directorates.

7.24 In 2016 the Trust introduced collective leadership under its 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels' strategy.[62] The purpose was to 'grow a culture of collective leadership where everyone at every level has the capability to deliver improvements for the Trust as a whole, not just in their own roles or work areas.' The Trust stated that its ambition was 'to make Belfast Trust a world leader in the provision of health and social care' and that the Trust be recognised as a high performing organisation. Our focus is on continual learning and the improvement of care that is safe, effective, high quality, and compassionate.' The Collective Leadership strategy also was designed to align with the Trust's learning and development strategy, 'Growing Our People today for tomorrow – living our value of maximising learning and development.'

[62] Leadership & Management Framework

7.25 The Collective Leadership strategy aimed to embed leaders at all levels in the organisation working towards high performance and improvement: 'the ethos is not dependent on position, grade or role and has the potential to more effectively transform the organisation and our Trust Ambition. All staff can be leaders and can demonstrate leadership qualities and behaviours.' The strategy sought to place responsibility for the success of the Trust as a whole while being successful in their work roles. The strategy acknowledged that it would take time to 'review our current culture, look at what works well and identify what needs to be improved. This will inform our new collective leadership strategy.'

7.26 The characteristics of culture set out in the strategy were:

- an inspiring vision;
- clear objectives and priorities at every level;
- supportive people management and leadership;
- high levels of staff engagement;
- learning and innovation the responsibility of all; and
- high levels of genuine team working and cooperation across boundaries.

7.27 The values expected of staff set out in the strategy were:

- 'being respectful to others;
- showing compassion for those who need our care;
- acting fairly;
- acknowledging the good work of others;
- supporting others to achieve positive results;
- communicating openly and consistently;
- listening to the opinions of others and acting sensitively;
- being trustworthy and genuine;
- ensuring that appropriate information is shared honestly;

- actively seeking out innovative practice;
- participating in new approaches and service development opportunities;
- sharing best practice with others;
- promoting the Trust as a centre of excellence;
- acting as a role model for the development of others;
- continuing to challenge my own practice;
- fulfilling my own statutory and mandatory training requirements;
- actively support the development of others;
- taking responsibility for my own decisions and actions;
- openly admitting my mistakes and sharing learning from others;
- using all available resources appropriately; and
- challenging failures and poor practice courageously.'

7.28 The Review Team was informed that the community sector of the Trust did not respond well to the collective leadership strategy. The reaction was described by a former Director as the community sector being 'up in arms.' The view was that the strategy was more appropriate to the acute sector. Interestingly, in reference to medical engagement the Leadership Framework stated that, 'there is clear and growing evidence that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins the argument that medical engagement is an integral element of the culture of any healthcare organisation and the system and therefore one of the highest priorities within an organisation.' The Review Team found little evidence of proactive engagement between managers and medical staff on the MAH when it came to the quality and safety of patients.

7.29 The Review Team saw no evidence of work being undertaken at MAH on a review of culture or of a learning and staff development programme to support the implementation of the Collective Leadership strategy. The practices which were captured by the CCTV footage from August 2017 also were not informed by

the value statements set out in the strategy. Training and staff development have been addressed at Section 6 (Paras 6.106 - 6.115).

iii. Leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels

7.30 There were at various times four Executive Directors with professional and managerial responsibilities for staff based at MAH namely: the Director of Adult and Primary Care; Director of Social Work; Director of Nursing; and clinical leadership which was provided by the Clinical Director. There was limited information on the documentation examined of the extent of the role at MAH. A copy of the Clinical Director's Job Description references the role in clinical leadership. The post-holder was accountable to the Co-Director of Learning Disability Services and professionally accountable to the Trust's Medical Director and from 2016 to the Associate Medical Director.[63]

7.31 The Clinical Director regularly attended a range of senior management meetings, including Governance and Core Group meetings. In his evidence to the Ennis investigation he stated that he completed a weekly ward round whereas the specialist doctor for the ward would have had a daily presence on the ward. Overall, he concluded that the ward was effectively managed by nursing personnel. There is evidence that at times the Clinical Director was not supportive of approaches recommended by ward staff and the Service Manager in relation to developing care and protection plans for patients. His view was that the suggested

[63] Extract from Job Description: 'The appointee will provide clinical leadership and contribute to the strategic development of the Service Group across the Trust and participate as a member of the clinical service senior management team. He/ she will provide professional advice to the Co-Director and Associate Medical Director on professional medical issues of the service. He/she will have a key role in developing clinical leadership and ensuring ownership of new strategies and policies within the clinical service area and of ensuring excellent communications between clinicians and the management team of the Clinical Service area as well as Service Group. The appointee will be professionally accountable to the Associate Medical Director for medical professional regulation within the service.

approach was required for forensic patients only. The follow-up action required of medical staff as part of policy when patients were subject to restraint, seclusion, or physical intervention was not always evident. The staffing pressures on the medical side and the difficulty in recruiting medical staff, which was regularly documented, likely contributed to a number of these omissions.

7.32 There is limited evidence of the Clinical Director promoting positive behavioural support approaches to patient care or of challenge to the high levels of restraint and seclusion which were used regularly especially in respect of a small cohort of patients. It is evident from minutes of meetings attended by the Clinical Director that he was aware of these matters and was very familiar with specific patients and their needs. The Clinical Director regularly attended Core Group meetings at the hospital where data regarding these practices were routinely shared. There is no evidence of a challenge function being exercised in an effort to change practice as a means of reducing incidents. The *A Way to Go* Report found that:

- ‘There was a culture of tolerating harmful and disproportionately restrictive interventions.
- The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic.’
- Reference to patients’ mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend “Keeping Yourself Safe” training.’[64]

These findings confirm for the Review Team that clinicians at MAH did not contribute to ensuring that safe and effective treatment was available at all times on site.

[64] Op. Cit. par. 4, Pages 4 - 5

7.33 The Review Team also found the absence of either medical or nursing staff at MAH competent to address the physical health needs of patients to be concerning. The Review Team identified a number of instances where patient's physical health needs remained undiagnosed and untreated for unacceptable lengths of time. The health inequalities which exist between learning disabled and the general population are well recognised.[65] There is evidence in the documentation examined of efforts made to procure GP and out-of-hours medical cover from services local to MAH. There was significant delay in procuring such services. As a hospital service the Review Team are of the view that greater pressure should have been applied to ensure the Trust took corrective action in respect of this shortcoming.

7.34 The Clinical Director briefed the Trust's Medical Director on 20th September 2017 immediately after viewing the CCTV footage at the PICU of the assault on a patient on 12th August 2017. He also informed the Medical Director that the footage also showed ill-treatment of another patient and the inaction of other staff. The Medical Director's notes of the meeting draw a conclusion that 'the whole staff team [at PICU was] complicit.' On learning of events on PICU the Medical Director requested that an independent SAI be established to review events at MAH; she extended this review to other wards.

7.35 When the Review Team met with Clinical Director he stated that in addition to his role at MAH, he also held the regional lead for forensic services and provided outpatient clinics. He was managerially responsible for medical personnel at MAH until after 2017 when his role changed. He advised that he had submitted requests to the commissioning Board for additional medical input. He was unsuccessful in securing additional staffing in either case. He noted the significant delay in

[65] People with a learning disability have worse physical and mental health than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017). Mencap https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

discharging patients due to the absence of a sufficient range of community resources. At the time of interview he noted that there were fewer than 60 patients in the hospital of whom around five required treatment or assessment. In discussing the use made of data provided at meetings which he attended regarding incidents involving vulnerable adults; physical intervention, seclusion, and restraint, the Clinical Director agreed that prior to 2017 information was viewed on a meeting by meeting basis rather than trend data analysed to inform alternative strategies or training. He noted that recent presentation of data was more trend focused. The Review Team found little evidence that the Clinical Director played a proactive leadership role in the management team.

7.36 The Review Team considered leadership at a range of levels across the Belfast HSC Trust in respect of MAH. An examination of Trust Board and Executive Teams' minutes showed that MAH rarely featured on the agenda. There was no reference to it in the Trust's Annual Quality Reports or within the Discharge of Statutory Functions Reports (DSF). The Review Team considered the repetitiveness of the DSF reports and the general absence of assurance regarding the degree to which statutory functions were discharged should have resulted in challenges at Trust Board and HSC Board levels.

7.37 Neither the vulnerability of the patients cared for at MAH nor an awareness of the likely risks associated with institutional living brought MAH into focus at any level at Trust Board or Executive Team levels. The Review Team concluded that for a number of reasons MAH was perceived, as one Co-Director noted, as a self-contained community with its own culture and identity. Its geographic distance from the Trust and the resettlement plan for the hospital led in the Review Team's opinion, to it being viewed as a place apart. MAH had no champions at either the Executive Team or at Trust Board levels with a curiosity about it and those for whom it cared. The Review Team concluded that the Trust's values (see Para 7.10) and the objectives established in *The Belfast Way* (see Para 7.9) were not

guiding principles at MAH. The Review Team identified a cultural divide between the Trust and MAH.

7.38 Organisational culture is a set of shared assumptions that guide what happens in organisations by defining appropriate behaviour for various situations.[66] Organisational culture affects the way in which people and groups interact with each other, with clients, and with stakeholders. Additionally, organisational culture may influence how much employees identify with their organisation.[67] A deeply embedded and established culture illustrates how people should behave, which can help employees achieve their goals. This behavioural framework in turn ensures higher job satisfaction when an employee feels a leader is helping him or her complete a goal.[68] Organisational culture, leadership, and job satisfaction are all inextricably linked.

7.39 The Review Team found low levels of staff morale reported by a range of interviewees and by staff whom they met during the visit to MAH in February 2020. It also found significant leadership issues in that events which occurred at MAH were seldom brought to the attention of the Executive Team, the Trust Board, the HSC Board, or the Department of Health. The culture at MAH appeared not to be influenced by the Trust's modernisation agenda or its value base. It also found expression in the reluctance of a number of managers to embrace the resettlement agenda by accepting the implication for the hospital's future and to learn from good practice to ensure a higher proportion of patients made a successful transition to community living. Such an approach may also have served to allay the fears and

[66] Ravasi, D. & Schultz, M. Responding to organizational identity threats: Exploring the role of organizational culture. *Academy of Management Journal,* 2006, 49 (3): 433–458

[67] Schrodt, P. The relationship between organizational identification and organizational culture: Employee perceptions of culture and identification in a retail sales organization". *Communication Studies* 2002, 53: 189–202

[68] Tsai, Y. "Relationship between Organizational Culture, Leadership Behavior and Job Satisfaction." *BMC Health Services Research BMC Health Serv Res,,* 2011 (11)1, 98

apprehensions of family and carers of patients who were understandably concerned about changes to the living environment of their loved ones.

7.40 The lack of Trust Board and Directors engagement with MAH is understandable given the scale and complexity of the Belfast Trusts and the degree to which the acute agenda dominated Executive and Trust Board meetings. It is not however, an excuse for having MAH operate under the radar with little effective challenge at the failure of its leaders to bring issues relating to the service to the attention of the Trust Board. A closed institution carries associated risks regarding the wellbeing of residents. This has been well established in institutions such as prisons, children's homes, and other learning disability services.[69] Visible leadership with regular engagement with a service and its staff is an important means not only of being alert to possible problems in a service but also of communicating the organisation's values and objectives for the service.

7.41 In the Review Team's opinion, how the physical environment was maintained conveyed a message to staff about how the hospital was valued by the Trust. Much of the hospital had been allowed to deteriorate over time and problems which emerged were addressed in-house in reactive fashions. For example, to solve issues relating to staff shortages wards were closed earlier than planned with insufficient attention afforded to the mix of patients in the amalgamated wards. Similarly, staff shortages resulted in fewer activities for patients which had negative consequences in relation to their management and behavioural challenges.

7.42 In the opinion of the Review Team the role of leaders is to interrogate and analyse information to develop approaches to proactively address root causes. Yet the absence of behavioural support staff meant there was no strategy in place capable of reducing incidents of physical intervention, restraint and/or seclusion. From a

[69] The Winterbourne Review, 2012 https://www.nhs.uk/news/medical-practice/winterbourne-view-failures-lead-to-care-system-review/#:~:text=The%20report%20into%20the%20events,reports%20of%20abuse%20were%

number of correspondences between one Ward Sister and her line manager it is apparent that she stopped raising issues of concerns because it made no difference and her concerns remained unanswered. Addressing one's own difficulties without support obviously caused this Ward Sister to feel ignored and frustrated. The degree to which her views were representative of opinions across MAH is not known.

7.43 The Review Team concluded that a number of MAH senior managers attempted to deal with issues in-house, rather than escalate them to Director level. The Review Team considered that this was one possible explanation for why an SAI was not competed in November 2012 in respect of the Ennis Investigation by MAH staff (see Para 8.30)

7.44 A culture which separated MAH from its parent Trust is evident. The Review Team noted MAH staff's desire to train on-site rather than at Trust locations. When patients became ill or needed hospital treatment staff also elected to attend at a Northern HSC Trust facility rather than one of Belfast Trust's hospitals. There was no sense that MAH staff felt a loyalty to the Belfast Trust.

7.45 In 2012 the Trust Board agreed to meet at each of its facilities to increase its visibility with staff groups and to apprise itself on the range of services it provided. The first Trust Board meeting at MAH was held in 2016. The priority afforded to MAH is possibly reflected on the Trust's website which until July 2020 did not list MAH as one of its hospitals.

7.46 When events of August 2017 were brought to the attention of the Trust Broad on 20th September 2017 it decided to appoint an External Assurance/Support Team. The purpose of the Team was to provide independent assurance to the Trust Director lead Governance and Improvement Board in relation to the response to the serious safeguarding concerns in Muckamore Abbey Hospital. The Team

consisted of the Trust's Adult Safeguarding Specialist, a Professor of nursing and learning disability (Ulster University), and a senior professional officer at the Northern Ireland Practice and Education Council (NIPEC). Proposed priority areas for the Team to review were:

- model of service delivery;
- advocacy arrangements;
- nursing staffing levels, skill mix, training and education;
- enhanced monitoring;
- Adult Safeguarding processes; and
- the viewing of CCTV footage.

7.47 A Director's Oversight Group was also established. The group met on a weekly basis to review the Action Plan for Protection of Patients with the service management team, provide support, and offer an 'open door' to any staff member who wished to speak to the Directors. Directors have also visited clinical areas. The current action plan considered actions under the following headings:

- enhanced monitoring;
- improving staffing;
- communication;
- reflection and learning;
- adult safeguarding; and
- disciplinary investigations.

7.49 The Trust Board also established in January 2018 an independent Review Team under the leadership of Margaret Flynn to investigate adult safeguarding at MAH as a Level 3 SAI. The resulting report was published in November 2018.

7.50 An examination of the Executive Team and Trust Board's minutes since CCTV footage came to light demonstrated the higher priority afforded to MAH. The senior

leadership team, which has since been deployed at MAH, represents personnel with significant expertise. The Review Team considered that this level of attention will be required in the future to ensure that safe, effective, and compassionate care is available to patients who are some of the most vulnerable citizens in Northern Ireland.

Summary Comments and Findings

- **The Belfast Trust made significant efforts after the RPA to develop clear strategic direction and sought to communicate this to its staff and citizen.**

- **The Executive Team and the Trust Board accepted MAH as a place apart from the rest of the Trust. The scale and complexity of the Trust and its focus on acute services meant that there was a lack of engagement with or curiosity about MAH. There is no evidence of senior people championing the hospital.**

- **There was a lack of evidence that the Trust Board or Executive Team displayed interest or curiosity about MAH. The site was rarely visited.**

- **The frequent changes in Trust management structures did not provide stability for those trying to provide learning disability services. Staff at MAH were at times unclear about who the Directors were with responsibility for the service.**

- **The Trust's focus was on resettlement of patients in MAH. This came at the cost of scrutiny of the safety and quality of care of those in the hospital.**

- **Issues of real concern such as staffing matters were not escalated by the Director of Adult and Primary Care or the Director of Nursing to the**

Corporate or Principle Risk Registers.

- **The appointment of the Service Manager in 2012 from outside Learning Disability Services was met with hostility by some managers in MAH. There was a lack of support for her at times from her superiors and evidence of a dysfunctional senior team at MAH.**

- **There was reluctance within Learning Disability to let other parts of the Trust know what was going on in the hospital. The reluctance to use appropriately the SAI procedures was an example of this.**

- **Leadership on the MAH site was ineffective and did not prevent or challenge a culture of institutional abuse towards patients.**

- **There was limited evidence of effective medical leadership on the MAH site.**

- **The Trust's values and corporate objectives did not inform practice at MAH.**

- **There was a culture divide between the parent Trust and MAH which developed over many years.**

- **Trust Board members were not well served by those Directors who did not escalate matters such as the Ennis investigation to it.**

- **The absence of adequate medical cover to address the physical health needs of patients and behavioural support services to manage their behaviours resulted in harm being caused to some patients.**

- **Neither Directors nor Board members grasped the scale of the historic**

CCTV footage or its implications in the latter part of 2017 until 2019.

- **Steps taken since August 2017 have contributed positively to improvements to patients' care and wellbeing.**

8. Key milestones of the Review

8.1 The Review Team's approach to the three key events which occurred within the timeframe covered by its Terms of Reference is set out at paragraph 1.5. These events inform the structure of this section under the following headings:

i. the Ennis Report;
ii. CCTV; and
iii. the complaint made by a patient's father in August 2017.

8.2 The Review Team acknowledges that the three key stages may not fully represent standards of leadership and governance from 2012 to 2017. They do, however, provide the Team with robust information upon which to base its conclusions and recommendations.

i. The Ennis Report

8.3 The Review Team focused on the substance of the Ennis report and its subsequent influence on practice, culture, leadership, and governance at MAH rather than on any events subsequent to media involvement in October 2019. The following sub-sections reflects this approach:

a. a summary of the events which led to the Ennis Report;

b. the Ennis ward context - November 2012;

c. The Safeguarding Investigation

d. the processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same;

e. outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care;

f. governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations; and

g. observations and conclusion.

a. A Summary of the events which led to the Ennis Report

8.4 On the 8th November 2012 the Trust received allegations that four patients at Ennis Ward were the subject of verbal and physical abuse. The allegations were initially made by a staff member employed by a private provider. Other staff from this provider made similar allegations following the initial allegations. The external staff were working in Ennis to familiarise themselves with a number of patients who were scheduled to be resettled in a facility owned by the private provider.

8.5 The nature of the allegations made included:

- rough handling of some patients;
- alleged assaults;
- staff speaking inappropriately to patients;
- a patient being encouraged to hit back when she was attacked by another patient;
- patients hitting out at staff and each other without appropriate intervention; and

- issues relating to the management of patients around meal times which appeared distressing to some of them.

8.6 On receipt of the allegation three staff members (two nurses and a healthcare assistant) and a student nurse were immediately placed on precautionary suspension pending further investigations. The nurses were referred to the Nursing and Midwifery Council. The healthcare assistant was referred to the Disclosure and Barring Service.

8.7 A Vulnerable Adult Safeguarding Review was established immediately. The review was led by a Designated Officer (DO) not based at MAH, who was assisted by two social workers from the Trust's community learning disability team who acted as Investigating Officers (IOs). The investigation was conducted under the Trust's Safeguarding of Vulnerable Adults policy. Given the alleged criminal nature of a number of the allegations the investigation was conducted jointly by the Trust and the PSNI. The Trust's DO ensured that interviews took place with staff from:

- the Private Provider;
- Ennis ward;
- several patients who were potentially injured parties along with their relatives/carers;
- the Clinical Director; and
- the Specialist doctor for the ward.

Records indicate that interviews took place between 19th November 2012 and 15th May 2013.[70] The Review Team had access to witness statements which were taken as part of the Trust's investigation, excluding statements taken by the PSNI.

[70] There were 6 interviews with MAH staff which were undated and they are excluded.

8.8 The report into the Ennis investigation was completed in October 2013. Appendix 1 of the Ennis Report lists 63 incidents. In its examination of the incidents the Review Team was unable to determine the exact number of incidents. From its review of the records the Review Team identified a significant degree of duplication (see Appendix 6). Dates when the incidents allegedly occurred were not available. This made it difficult to deduce whether the same incident was referenced more than once using different terminology or whether there was more than one occurrence.

8.9 The Review Team found it difficult at times to determine the precise nature of the allegation being made. This difficulty was compounded by the statements provided by four staff from the Private Provider made to the Trust's Human Resources personnel in 2014. Information available from the IOs and the Human Resource department meant that the Ennis Review Team identified conflicting information on a number of matters. These included the level of induction available to the private provider's staff, the nature of interaction with patients, and the assistance provided by Ennis staff. A significant number of alleged incidents were deemed by the Review Team to be of a practice nature and related to the care of patients by both nurses and healthcare assistants. They indicated the likelihood of a culture prevalent in the ward at that time.

8.10 As a result of its investigation the PSNI charged a nurse and a healthcare assistant with a number of common assaults and ill-treatment of patient. At trial the nurse was acquitted while the healthcare assistant was found guilty on one count of common assault which was subsequently overturned on appeal.

8.11 The healthcare assistant retired and resigned from the MAH bank pool of staff at the conclusion of the police investigation. A disciplinary investigation was commissioned in respect of the nurse. The Review Team was advised that only one of the allegations made against this staff member was capable of being taken

to a disciplinary hearing. The nurse returned to work for a short time, although not in Ennis ward, and retired shortly afterwards.

b. The Ennis Ward Context - November 2012

8.12 Ennis was a resettlement ward caring for 15 patients. The Review Team considers the circumstances under which patients lived and staff worked at the time of the allegations as significant. This is because they provide a context to assist an analysis of the day to day running of the ward. The *A Way to Go* report commented that, 'the ward environments impact on patients, their families and staff.'[71] Similarly, Prof Ian Kennedy, who chaired the Kennedy Review into the practice of the breast surgeon Ian Paterson, noted that: 'at times of stress in an institution, the first people who are overlooked are patients.'[72]

8.13 Documentation examined by the Review Team noted that Ennis staff had expected the ward to close in December 2012 and had already held some events to mark the planned closure. Similarly, the ward environment had not been maintained due to its imminent closure. The ward was described as overcrowded and lacking in space. Challenging behaviours were at a level which caused difficulties on the ward.[73]

8.14 The Review Team was advised that MAH was exempt from cash releasing measures in 2012/13 as it was envisaged that the £1m it was required to release would be achieved by ward closures. The Review Team was further advised that MAH on an annual basis had an operating surplus which was used to offset overspends in the community learning disability services.

[71] A Way to Go, Page 43, par. 2
[72] Seven Organisational Weaknesses – Prof Ian Kennedy on the Ian Patterson Report
[73] Ennis Investigation File Page 62

8.15 The nurse to patient ratio was also reported to be low in Ennis with a high ratio of healthcare assistants. The Review Team was advised that a staff ratio of 20:80 nurses to healthcare assistants pertained at times in Ennis. RQIA in its response to the draft Ennis Report stated that, 'staffing shortages appear to be a significant contributory factor to the allegations. There are issues of redeployment and concerns expressed regarding bank and agency staff.' More concerning was an RQIA comment in the same document that, 'the issue of staffing levels is a recurrent theme and particularly as staff move more frequently from Ennis to other wards.'

8.16 The uncertainty around the hospital's future caused recruitment difficulties. Coupled with staff shortages this resulted in a high reliance on bank and agency staff for cover. The Review Team was told that some staff worked bank hours resulting in a working week of 70 - 80 hours. At times, the ratio of registrants on duty was as low as 20% of those on duty. Staffing concerns were not unique to Ennis. By March 2012 hospital managers had escalated the staffing situation by placing it on the MAH Risk Register at red, which the Service Manager told the Review Team meant it had been brought to the attention of the Trust Board. The examination of the Trust's Corporate and Principle Risk Registers[74] found, however, no reference to the staffing crisis at MAH.

8.17 Staff shortage resulted in the curtailment of patient activities in Ennis. RQIA stated that it 'was not aware of activities happening at Ennis during previous inspections.'[75] In the documentation examined by the Review Team, the lack of activities correlated with behavioural issues. It also meant that at times it was impossible to maintain agreed observation levels. The ward manager reported these concerns to her line manager.[76] The Telford Formula was employed in MAH

[74] Corporate Risk Register – Trust Executive Team. Principle Risk Register – Trust Board.

[75] RQIA response to draft Ennis Report 2nd August 2013

[76] Op. Cit., Page 67

to agree staffing levels. The Ennis Report voiced concerns about its appropriateness, as did RQIA, especially given the mix of patients requiring care on the ward.

8.18 The Ennis ward was structured in two halves; upper and lower. The upper half having six patients who were deemed to be more able than the nine patients cared for in the lower half. Patients in the lower half of the ward had complex needs and challenging behaviours; this area was locked as a means of protecting them. The Review Team had access to internal correspondence from the Ward Sister to her line manager expressing concerns about the mix of patients and the skill mix of the staff team, which she deemed to be inappropriate to meet the patients' needs. Other correspondence stated that there was insufficient staff to enable the ward to progress its remit as a resettlement ward.

8.19 The Review Team was advised that in November 2012 Ennis Ward had four patients to a bedroom. Although the ward was overcrowded, therapeutic space for patients had nevertheless been reassigned by the Ward Sister to provide additional accommodation for staff. The furniture in the ward was described as very old. There were few chairs and sofas and furniture reportedly did not meet the mobility needs of a number of patients. An Internal Audit of the Ward undertaken on 12th December 2012 and updated on 19th February 2013 comprehensively reviewed the ward. Its subsequent 17-page report lists a range of environmental shortcomings. The ward was described as dull, dismal, and un-stimulating by staff from the private provider's service.

8.20 MAH was registered as a hospital. Efforts to bring the Ennis ward up to hygiene and infection control standards meant changes were made, for example, to the display of patients' artwork and arrangement of ward decorations. This caused a culture clash between those who viewed the ward as the patients' home and those seeking to apply the standards required of a hospital. There is no information on

the records examined of discussion with RQIA to inquire in what ways patients' living space could be maintained.

8.21 The service manager when appointed in 2012 had an objective to resettle where appropriate patients into community settings. This would allow the hospital to have a core focus on treatment and assessment. Her agenda, which was in keeping with that of the Bamford Reviews, the Department of Health, the commissioning HSC Board, and the Trust was met with resistance from a number of staff as well as from patients' carers and relatives who had come to view MAH as a home setting. As many patients had lived there for decades, concerns expressed about resettlement are understandable. The idea of a hospital as a home is not a sustainable way forward for those with learning disabilities.

8.22 Ennis was not viewed as an environment fit for its purpose as a resettlement ward according to information provided to the Review Team; this conclusion was not unique to Ennis. In respect of the other resettlement wards examples provided were of wards with dormitory sleeping arrangements of up to 10 patients with no potential for individualisation.

8.23 As activities in the ward were limited a number of sources referred to resulting boredom and lack of stimulation among patients. The removal of the ward's car also denied the opportunity for patient outings. The *A Way to Go* report reported the views of a patient advocate who observed that: 'there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards.'[77] Often staffing difficulties, which was a common feature across MAH, limited patients' ability to attend the onsite day care centre as there were insufficient staff to take them there.

[77] Op. Cit. Page 25, par. 87

8.24 The physical environment on the ward as described to the Review Team was considered to be un-conducive to the promotion of a patient centred approach to care. It is apparent from witness statements accessed by the Review Team that staff who worked in the lower part of the ward felt less favourably treated. It is likely, in the opinion of the Review Team, that patients may also have experienced similar sentiments.

8.25 In addition to a dated and un-stimulating physical environment, Ennis also largely functioned on a uni-disciplinary basis. The Review Team was told that a multi-disciplinary approach was absent within the ward, that there were no occupational, behavioural, speech and music therapies, nor social worker attached to the ward. The Review Team was informed that in contrast, MAH in November 2012 had:

- 1.5 speech and language therapists;
- 0.5 dieticians;
- a psychologist;
- two physiotherapists;
- a technical assistant responsible for aids and appliances; and
- three social workers.

There was no pharmacy cover at the hospital. GP services were contracted from an Antrim practice to meet patients' physical health care needs. On site input from psychiatric services was also limited as the psychiatrists also had duties in respect of outpatient clinics across the region. The absence of an agreed medical model reportedly resulted in tension between psychology and psychiatry services within the hospital according to information provided to the Review Team. It is noteworthy that at this time (2012) there were some 250 inpatients in MAH.

8.26 The Ennis ward's staff and patients faced significant challenges across a range of measures. The private provider's staff who complained about patient care in Ennis,

had come to work in an environment very different from the modern facility to which they were accustomed.

c. The processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same

8.27 The allegations received by the Trust on the 8th November 2012 could have been dealt with potentially as:

- a complaint;
- a Serious Adverse Incident (SAI); and/or
- an adult safeguarding investigation.

8.28 On receipt of the allegations the decision was made to process them as a safeguarding matter under the Trust's safeguarding vulnerable adults' policy. This decision in the opinion of the Review Team had a number of consequences. It meant that the allegations were then all classified as being of a safeguarding nature, although this was not the case. It also meant that there was no formal arrangement to bring the safeguarding investigation to the attention of the Executive Team of the Trust's Board. In the case of complaints and Serious Adverse Incidents, arrangements exist to apprise the Trust Board of such complaints and incidents through relevant reporting arrangements.

8.29 A review of Appendix 1 of the Ennis Report shows that a number of the complaints related to poor practice and issues of care. Concern was expressed about the level of induction for staff from the private provider and the degree to which patient information was shared with them, as well as the level of support provided to them by MAH staff. In the opinion of the Review Team, allegations should have been disaggregated in such a way as to ensure the safeguarding investigation's focus

was maintained which would have enabled practice issues to have been addressed more expeditiously.

8.30 In its wider consideration of structural issues in Ennis and across MAH, the Review Team concluded that in addition to the safeguarding investigation, the allegations should also have triggered an SAI. An SAI is defined as 'any event or circumstance that led or could have led to serious unintended or unexpected harm, loss, or damage to patients. This may be because:

- It involves a large number of patients;
- There is a question of poor clinical or management judgment; …
- It is of public concern;
- It requires an independent review.

The Health and Social Care Board, with input as appropriate from the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA), reviews each incident and decides whether any immediate action is required over and above that which has already been taken by the reporting organisation. The reporting organisation is required to carry out an investigation into the incident and forward a report within 12 weeks to the Health and Social Care Board.'[78]

8.31 The Review Team had access to correspondence between the HSC Board and the Belfast HSC Trust where the former asked on multiple occasions from the 6th February 2013 until the 3rd September 2015 for an SAI to be submitted in respect

[78] NI healthcare: What is a serious adverse incident? 6th October 2016 https://www.bbc.co.uk/news/uk-northern-ireland-37563833#:~:text=A%20serious%20adverse%20incident%20is,loss%20or%20damage%20to%20patients.

of the Ennis allegations. [79] On the 7th September the Trust accepted that it was in breach of both the 2010 and 2013 SAI procedures but was content to live with the procedural breaches as the allegations were not substantiated by the safeguarding investigation. The Review Team was concerned that acceptance of such a breach would have occurred without the approval of the Trust Board. In its discussion with Trust Board members it is apparent that they were not aware of this admission. Similarly, the Review Team considers that the HSC Board should seek to assure itself that any such admission has been endorsed by the Trust.

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[79] Request 6th February 2013 asking if the Early Alert is closed as no SAI has been received. 4th March 2014 email noting no SAI has been received and asking if the Early Alert is closed. 6th March 2014 email requesting to Trust notify the Trust given the serious nature of the allegations and in the public interest the Board views this as an SAI, apologies for not picking up earlier that an SAI had not been received; notes the Early Alert remains open. The Trust replied on 28th January 2015 stating the Early Alert remains open and the matter has been investigated under safeguarding arrangements not as an SAI. Advises the Early Alert should be closed. HSC Board replies stating the incident appears to meet Criteria 4.2.5 and 4.2.8 of the SAI Procedures for Reporting and Following up of SAI (October 2013). It notes while appropriate to delay SAI on the request of the police that Section 7.3 of the procedures expects that the SAI will run as a parallel process. 'The intention and scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding Investigation.' The Trust is requested to formally notify the HSC Board of the incident as an SAI and conduct a review of this case in respect to care planning, staff supervision, training etc or any cultural or environmental features in the care setting that could be addressed to reduce the likelihood of future reoccurrence. The Trust responded on the 13th May 2015 stating that the y had made the decision on the basis of the 2010 procedures which were extant at the time of the incident. The HSC Board responded on the 23rd July 2015 noting that under Section 3.3 of the 2010 procedure an SAI should have been completed. The Trust was again asked to submit an SAI in respect of the incident. The Trust responded on the 5th August 2015 stating the matter had been investigated by the PSNI and an 'extensive safeguarding process' and that 'there was no evidence of any of the allegations made.' The Trusts requested that the Early Alert be closed. 28th August 2015 HSC Board responded it would prefer to keep the Early Alert open until an SAI was received from the Trust. 1st September 2015 the Trust's explanation for its decision not to submit an SAI as requested 'the safeguarding investigation found the allegations were not substantiated and as such does not meet the SAI criteria.' The Trust acknowledged that it should have been dealt with as an SAI at the time but would have been deferred pending the conclusion of the safeguarding investigation. If it had been reported as an SAI it would then have been de-escalated given the unfounded allegations. If the Trust did now submit it would also be asking for it to be de-escalated due to the unfounded allegations. Trust felt referral now would be a paper exercise. The Board agreed to close on the following wording from the Trust: 'HSCB are content to close this early alert on the basis BHSCT have advised the safeguarding investigation found the allegations were not substantiated. It should be acknowledged at the time the early alert was reported, a SAI notification should also have been submitted, which could subsequently have been deferred pending the outcome of the safeguarding investigation.' The Board replied on the 3rd September noting if the Trust could live with the breach in respect of SAI reporting the HSCB could. The Trust replied on the 7th September 2015 stating it could live with this breach.

8.32 As a result of the criminal investigation led by the PSNI, two members of staff faced criminal charges. One staff member was acquitted at initial hearing while the other's conviction was overturned on appeal. The standard of proof in criminal trials is defined as being beyond reasonable doubt. On the other hand, the balance of probability test means that a matter is more likely to have happened than not. This lower standard of proof is usually used by social services in determining the likelihood of harm/risk in safeguarding cases. The Trust repeatedly advised the HSC Board that the safeguarding investigation was unable to substantiate the allegations even though the Public Prosecution Service determined that charges should be brought. The Review Team was concerned about the Trust's approach due to the threshold applied in this matter. The definition of evidence and a decision on whether the Ennis allegations constituted institutional abuse were still unresolved at the time of the last Adult Safeguarding Case Conference held on the 28th October 2013. An internal email dated 24th January 2013 which was copied to the DO leading the safeguarding investigation, stated that, 'there is a concern of possible institutional abuse and a full understanding in terms of culture and past history on Ennis is relevant.' These matters are analysed in paragraphs 8.36 to 8.62 as part of its wider consideration of the adult safeguarding investigation.

8.33 The Review Team considers that the Ennis allegations merited the submission of an SAI either to operate in parallel with the safeguarding investigation or to have taken place at its conclusion. The SAI policies for 2010 and 2013 would have facilitated either approach. The Review Team concluded that:

- the Trust failed adequately to interpret the SAI reporting criteria;
- the potential existed for a fuller investigation of events at Ennis, which could have identified many of the issues described in the *A Way to Go* report (2018); and that
- factors contributing to the situation subsequently captured on CCTV during 2017 included: the staffing crisis, the focus on resettlement, ward closures,

patient mix, the lack of a multidisciplinary approach, and excessive levels of seclusion, restraint and staff overtime.

8.34 The Review Team could find no explanation as to why the Trust opposed an SAI in respect of the Ennis allegations. The capacity existed for local managers on the MAH site to control this aspect of the investigation as the safeguarding aspects were being managed off-site. In discussions with Trust Board members the Review Team was told that MAH was 'not in their line of sight' of the Trust Board and that a lack of curiosity pertained among its senior managers, the consequence of which was a lack of scrutiny or analysis of events at the hospital, in the Review Team's opinion. The Board members expressed their profound regrets and shame for the events at MAH. The Trust Board has since made efforts across a range of systems to ensure the safety and wellbeing of patients. While the 2018 - 2020 period falls outside of the Review Team's Terms of Reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions.

8.35 Wider structural accountability could, in the opinion of the Review Team, have identified from the Ennis allegations the hazards associated with inadequate staffing, the deficient governance and leadership arrangements, and the potential for institutional abuse. Such awareness might have led to the introduction of mitigating strategies which in turn could have prevented the abuse captured on CCTV and the complaint of abuse by a patient's father in August 2017.

d. The Safeguarding Investigation

8.36 The following section considers the conduct of the safeguarding investigation. The initial safeguarding referral resulted from disclosures from a care assistant employed by a private provider who had been working on the ward on 7th

November 2012. She then 'witnessed patients [sic staff] being verbally and physically abusive to four named patients.' Three of these patients were from the BHSC Trust and one from the NHSC Trust's areas.[80] The Care Assistant identified three staff and one student nurse in her allegations. Her concerns were reported to her employer's team leader at ten o'clock that evening. Steps were taken the following day to ensure the Trust was alerted to the care assistant's allegations.

8.37 The decision to conduct an adult safeguarding investigation was taken upon receipt of the allegations on the 8th November 2012 by the Operations Manager for the Trust's Community Learning Disability Treatment and Support Services. In the absence of her line manager, the Operations Manager decided to lead the investigation. She took appropriate action to ensure the immediate safeguarding of patients and notified the PSNI as per the Trust's protocol for the Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults. Staff members implicated in the alleged abuses were immediately subjected to precautionary suspension.

8.38 On 29th November 2012 the Operations Manager drafted a letter to family members/ carers of Ennis patients seeking to furnish them with an update on the safeguarding investigation. The Co-Director for Learning Disability when provided with a draft of this letter determined that further discussion was required before an update could be produced. On 18th and 19th January 2013 a shorter, less informative letter was issued.

8.39 The Investigation Officers (IOs) contacted relatives/carers of patients in Ennis to ascertain if they had any concerns about the care provided. This resulted in

[80] In an email dated 29th November 2012 the NHSC Trust confirmed that it would be represented at adult safeguarding case conferences but 'responsibility for updating families by phone and letter should remain with BHSCT ensuring a consistent approach.'

minimal supporting evidence for the investigation. Family members and carers were advised that they would be kept up to date with the investigation's progress.

8.40 In an email dated 17th December an IO wrote to the DO stating that of the eight families contacted, one had expressed concern about patient care. In that instance a relative noted that his sister had claimed to have been taken by 'the scruff of the neck … to her bedroom'. He felt it was unlikely that his sister would tell lies but 'may not want to say anything that would get her into trouble.' None of the others expressed concerns about care on Ennis ward although two raised concerns about the future of the ward and their worries over its closure. One man noted the potential of any resettlement to disrupt his sister who had lived at the hospital for 30 years. Another interviewee related in a telephone interview on 8th January 2013 a number of concerns she had relating to low staffing number. She felt there was a need for staff in dayrooms at all times and was anxious about the level of supervision available for her sister. She was also concerned that her sister's money was not being spent on her. She felt her sister's clothing was shabby and that her sister was being over-medicated as she slept all afternoon. The overall assessment of the ward from this interviewee was, however, that 'the good outweighs the bad.'

8.41 Another telephone interview on 15th January 2013 took place with a patient's mother in which she reported that in her opinion the staff 'are very good'. She did however, express concerns about the number of incidents of peer assaults on her daughter. Another relative telephoned on the same day noting that there was in her opinion a lack of communication amongst the staff. The engagement with patients, relatives and carers made by the investigation staff in an effort to keep them informed and to seek their views was viewed positively by the Review Team.

8.42 Interviews with 17 MAH staff were subsequently undertaken and recorded. Six of the records are undated and most were unsigned. From the dates available it is

apparent that the majority of interviews (seven (64%)), took place between 8th and 15th May 2013: some seven months after receipt of the allegations. Two earlier interviews with MAH staff took place on 21st December 2012 with the remaining two taking place on 21st February and 8th April 2013.

8.43 The Review Team was concerned at the length of time taken to complete interviews with MAH staff. It was also perturbed at the timescale for the completion of clarification interviews with a patient who was an injured party who was deemed probably capable of giving evidence. This interview finally took place on 23rd January 2013. At that time the patient had no recollection of events of 7th November 2012 and did not want to engage in conversation about them. The Review Team was advised of a lengthy process involved in determining if patients have capacity and then acquiring necessary consent to be interviewed. Accepting that there are inevitable delays in completing such tasks, the Review Team concluded that a three-month delay with a learning disabled patient was not likely to result in good recall of past events.

8.44 An undated discussion between medical personnel, the PSNI, the Speech and Language Therapist, and the DO to determine capacity of Ennis patients identified 12 who could possibly give evidence. On 19th April 2013 an email from the DO to the Clinical Director sought his views on interviewing Ennis patients. The response was that one of the five patients had moved and that one patient's mental functioning had deteriorated. Given that Ennis patients have significant intellectual impairment, the Review Team considered the delay in interviewing them as likely to have further impaired their ability to contribute meaningfully to the safeguarding investigation.

8.45 Similarly, there was significant delay in police interviews with the two suspects. These interviews took place on 20th and 28th February 2013. An undated PSNI

report on interviews, which must postdate the 28th February, provided a summary of the evidence furnished by:

- the four private provider's staff;
- two relatives;
- the Forensic Medical Officer;
- the absence of evidence from the injured party; and
- the two suspects.

The report concludes with the PSNI's recommendation to the Public Prosecution Service to prosecute. The initial police interview with the complainant took place on 9th November 2012 with interviews of suspects not completed until 28th February.

8.46 There were eight case conferences or strategy discussions convened between 9th November 2012 and 28th October 2013. Appendix 7 sets out the information base for the Review Team's analysis of these meetings.

8.47 The second strategy discussion on 15th November 2012 did not commence with consideration of how aspects of the initial Protection Plan had operated. A revised Protection Plan was agreed. The staffing component of this was to be addressed by the DO with senior Trust managers. Professional practice at Ennis was the focus of much of discussion at this meeting. The Review Team considered that preliminary discussion with MAH managers and delegation of the staffing issue to them would have been a more inclusive working arrangement.

8.48 The third strategy discussion on 12th December 2012 addressed the issue of pending interviews. Considerable discussion took place around staffing on the Ward and the 24/7 monitoring arrangements. The Review Team considered that

greater focus was required on the handling of alleged incidents so that the safeguarding investigation could be brought to an early conclusion.

8.49 The fourth strategy meeting was held on 20th December 2012. Discussion at this meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run parallel. Additionally, in the view of the Review Team, it underlined the fact that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considered it essential that at the outset each allegation should have been assessed on the basis of the existing information. They should have been categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

8.50 In the fifth strategy meeting convened on 9th January 2013 initial focus was given to a consideration of progress against the actions established at the previous meeting. The Review Team considered such an approach commendable as it served to focus attention on any outstanding matters. The Co-Director of Learning and Disability Services, raised his concern about the list of allegations presented by the DO, some of which were specific while others were imprecise, negative comments. He stressed the need to obtain clear evidence and facts. The Review Team considered that had the initial allegation been disaggregated (see Para 8.29), the safeguarding investigation would have been able to focus its energies on abusive issues.

8.51 The sixth strategy meeting was held on 29th March 2013. This was almost two months later than initially scheduled. The focus of this meeting was the provision of an update from the PSNI and to plan further for the investigation. The first references to the potential for institutional abuse is recorded in these minutes. At the meeting it was agreed that all staff in the Ennis were to be interviewed by the two IOs. At this stage, five months after receipt of the allegations, neither patients

nor all of the staff working at Ennis had been interviewed by Trust staff. The Review Team considered this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

8.52 The seventh strategy meeting was held on 5th July 2013 during which copies of the draft final report were circulated. The Public Prosecution Service at this point still had to assign a public prosecutor to the case. One of the patient's interviews remained outstanding due to the absence of a Speech and Language therapist during July. The issue of initiating disciplinary proceedings was raised given the cost to the public purse. It was noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with private provider staff.' The DO noted that 'no evidence had been found to substantiate the allegations' but that 'the investigating team felt the [private provider staff] were credible.' Having read the minutes of the Case Conference of 28th October 2013, the Review Team concludes that there were sufficient concerns found to suggest a culture of bad practice. It is also evident that the private provider's staff identified good practice which the Case Conference considered 'would suggest that any poor practice was not totally widespread.'

8.53 The Review Team noted that:

- the report was not provided in a sufficiently timely manner to facilitate an informed discussion of it during this meeting;
- six months after the initially allegations were received patients had not been interviewed;
- the issue of staff disciplinary action and when it could be progressed had not been dealt with in a more timely fashion;
- the additional allegations made may have added considerably to the length of time for the investigation team to report without adding anything further to the body of available information;

- after such a lengthy review a more definitive conclusion about the culture of practice on Ennis ward had not been reached.

8.54 The final case conference meeting (for which minutes are available on case records) was held on 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation on Ennis ward. The DO noted the difficulty experienced by the investigation team in weighing the 'very different evidence provided by the two staff teams' [MAH and Private Provider staff]. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the private provider's staff's reports as evidence.

8.55 The Co-Director, Learning and Disability Services, noted at that Case Conference that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' The RQIA representative supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked to review minutes of previous meetings for any discussion of institutional abuse before the case conference would conclude on this issue. A further meeting was arranged for 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

8.56 The Review Team was of the view that there was significant delay in bringing the Ennis Report to a conclusion given that the draft report had been tabled for discussion at the strategy discussion convened on 5th July 2013. Action in relation to staff disciplinary proceedings was also delayed, and on the basis of this meeting was likely to remain so pending court hearings. In the Review Team's opinion, consideration of disciplinary action should, where possible, be pursued at the commencement of any investigation. Reasons for a decision on any deferment

should be provided in writing and be subject to monthly review. Such an approach would demonstrate greater regard and accountability for the public purse.

8.57 The Review Team was particularly concerned that at this late stage in the investigation process consideration was being afforded to the issue of whether or not the abuse was of an institutional nature. In the opinion of the Review Team this discussion should have occurred early in the investigation process to assist with informing the subsequent nature of the investigation. Such an approach would also have assisted the Trust to comply with the SAI procedures which it acknowledged it had breached (see Paras 6.19 and 8.31). In discussions with Trust specialists working with vulnerable adults the Review Team were advised by one individual that the allegations were unambiguously of an institutional nature while the other felt a decision centred on the way institutional abuse was conceived. The DO felt she was being pressurised by the Co-Director to state the investigation had not identified institutional abuse. In the DO's opinion she did not have enough evidence to reach a definitive conclusion.

8.58 From the case records examined the Review Team considered that:

- the Strategy Meeting extended its remit through its detailed consideration of the operation of Ennis ward rather than in establishing a broad framework to inform the safeguarding of patients. In the Review Team's opinion, concerns noted by the regulator (RQIA) in respect of staffing would have been better progressed through its usual regulatory functions rather than via the strategy discussion process;

- the DO appeared to have adopted an oversight function in respect of the operation of the Ennis ward by, for example, emailing the Service Manager at MAH on 5th March 2013 noting that from the nursing monitoring reports she could not identify whether or not staffing levels were appropriate. It is the

opinion of the Review Team that the action of the DO in this respect was not appropriate. It carried the potential to undermine the managerial system at MAH. The Review Team's view was that to report on the implementation of recommendations was the proper way to seek to monitor levels of compliance or non-compliance; and that

- the safeguarding investigation took from 8th November 2012 until 23rd October 2013. This is much longer timescale than one would have expected, especially given the nature of the complaints. Allowing for the significant amount of work carried by the DO, the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation. The time delay had significant implications for Ennis staff and the costs associated with precautionary suspensions.

8.59 The safeguarding investigation took some 11 months to complete. There is evidence of initial feedback on the investigation being furnished to relatives and carers. An extensive number of interviews took place with MAH nursing and clinical staff, staff employed by the private provider, patients deemed to have capacity, and the relatives/carers of Ennis patients. Many of these interviews were held some five and six months after the start of the investigation. The delay in interviewing patients was of particular concern to the Review Team as it reduced the likelihood of evidence being forthcoming. Given the general level of social functioning among patients, any delay reduced the likelihood of evidence being forthcoming. In the opinion of the Review Team the absence of dates and signatures from six of the interviews with MAH staff is a significant omission. There can be no certainty as to when these interviews took place. Five or six months into the investigation appear a likely timescale as the majority of MAH staff interviews were held in that period.

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8.60 It is apparent from an examination of the records of those interviewed that no clear consistent picture emerged from any of the groups interviewed. The Review Team considered that the allegations made in November 2012 should have been disaggregated to allow for safeguarding issues to be the sole focus of the investigation. Other matters should have been dealt with under the Trust's complaints procedure or its disciplinary processes which are in place to deal with poor practice concerns.

8.61 The Review Team views the failure to identify the failings reported at Ennis as an SAI as a missed opportunity to identify wider problems within MAH. Subsequent events confirm that a number of wider structural and cultural issues arising in the Ennis safeguarding investigation were not confined to that ward.

8.62 The Review Team concluded that the safeguarding investigation involved multiple victims and multiple perpetrators, as such it could have been identified as institutional abuse. At the last recorded case conference which was convened on 28th October 2013, the multidisciplinary team failed to reach a definitive conclusion regarding its status. In discussions with the DO, the Review Team was advised that the status of the review was the subject of numerous discussions with her line manager. She clearly felt under pressure to conclude that it was not institutional abuse. In the absence of comment from the Co-Director, the Review Team can reach no final determination as to his motivation. The reason provided by the DO for not classifying the Ennis allegations as institutional abuse was the absence of a definition of institutional abuse in the 2006 and 2010 safeguarding policies extant at the time of the investigation. While there is no definition in either policy, both refer to abuse in institutions.[81] In the opinion of the Review Team the history of previous inquiries at MAH provided a context supportive of an early consideration of the potential for institutional abuse.

[81] Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance, par. 3.3, Page 11, 2006 and the Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements, par. 13, Page 7, NIO / DHSSPS, March 2010

e. Outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care

8.63 During the course of the Ennis investigation a requirement was established for 24-hour monitoring of staff working on the ward as a protective measure for patients. The monitoring staff were employed at Band 6A levels at a minimum. They were in place for a period of some 9 months. The cost to the Trust was estimated to be in the region of £500,000. The Review Team was informed by the Trust's Director of Nursing that these monies were available from the in-year MAH budget. Approval of the Trust Board for this level of expenditure was not required. A weekly support meeting was established to discuss any concerns arising from the monitoring arrangements. The monitoring reports were also provided to the Operations Manager who was leading the safeguarding investigation as DO. There is evidence in the case records of discussion between the Operation Manager and MAH Service Manager to agree on action required as a consequence of the monitoring reports.

8.64 The establishment of 24/7 monitoring role meant that information on wider patient care issues were identified. These included:

- patient privacy;
- lack of stimulus/ lack of visual stimuli;
- no attempts to engage in therapeutic activities;
- overcrowding in the bottom dayroom; and
- lack of quiet space for patients;

8.65 As a result of the allegations a number of remedial actions were taken to improve the care and the quality of the environment on Ennis Ward. The Review Team noted that this included:

- an additional Ward Sister who was redeployed to Ennis for an initial period of two months from 8th November 2012 with a Deputy Ward Sister appointed from 25th November 2012;
- a review of the Telford staffing formula for Ennis ward which resulted in a subsequent increase in staffing levels;
- assurance to provide a minimum of six staff on duty during day shifts with additional resources deployed where possible. Night duty, up until 11pm, would also comprise six staff reduced to two for overnight duty; and
- a monthly monitoring of staffing ratios to ensure an appropriate skill mix in the staff team.

8.66 Service Improvement Action Plans were created for Ennis. Key steps included:

- leadership walk-arounds and viewing the environment with fresh eyes;
- safeguarding materials to be shared with staff and where required staff supported with training to facilitate and sustain improvements in practice;
- to uplift staff knowledge on current policy relevant to the environment as well as information governance/patient property;
- commissioning training restating the strategic objective of resettlement;
- reviewing the ward's learning environment for student placements.

8.67 A multidisciplinary team was introduced to Ennis to improve patient care with the appointment of a psychologist and improved access to behavioural support services. Greater focus was also afforded to stimulating patients through increased levels of activities. The enhanced staffing numbers further improved the 1:1 contact between patients and staff. A review of each patient's care plan and a functional behavioural analysis was also undertaken.

8.68 Despite the plan to close Ennis Ward, environmental improvements were made to enhance the living and sleeping arrangements in the ward. This was not only at a cosmetic level but a capital bid was approved to facilitate structural improvements.

8.69 Safety and hygiene checks were also undertaken on the ward with Estates Department to assist with improving the dignity and privacy of patients.

8.70 Considerable improvements occurred as an appropriate response to the allegations made in November 2012 and the staffing and environmental factors which in the opinion of the Review Team contributed to the events then noted.

f. Governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations

8.71 To deliver on improvements the Trust developed a series of monitoring arrangements in respect of the operation of the Ennis ward. In the opinion of the Review Team the secondment of a Co-Director of Nursing (Education and Learning) to MAH with a responsibility to monitor practice and to analyse information was a key means of ensuring not only an oversight function, but also a dynamic analysis of information. The support role to the Service Manager was also critical given the additional demands and challenges resulting from the safeguarding investigation.

8.72 The Co-Director of Nursing undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files, and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;
- consideration of progress against draft improvement plans; and

- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provided of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of MAH leadership and provided governance assurances to the Trust.

8.73 It is also evident that a previous consideration to fit CCTV in MAH, which was first raised in August 2012, was given added impetus as it was viewed as a means of addressing the factual discrepancies which emerged from the Ennis investigation. This matter is addressed further in the CCTV section from paragraphs 8.81 to 8.112.

8.74 No information was available in case records on how the safeguarding investigation was subject to governance controls. The DO's line manager attended a significant number of the strategy meetings/case discussions. From recorded comments it was apparent to the Review Team that there was no agreed approach about the nature of the investigation, what constituted evidence, and when disciplinary action should be initiated. The Review Team considered that while the DO must act independently, leadership support is required in discharging this challenging role.

8.75 There was no apparent reason for a number of the delays evident in the safeguarding investigation. From July to October 2013 the aim of the final two strategy discussions was to focus on the conclusions and recommendations of the Ennis report. A three-month period between reviews is within the policy requirements. The Review Team deemed that arrangements should have been put in place to ensure that no drift occurred in the investigative process. Delays in interviewing patients, and MAH and the private provider's staff, which the Review Team deemed unacceptable, should have been identified and remedied.

g. Observations and conclusion

8.76 The Review Team considers that the Ennis safeguarding investigation was hampered from the outset by the fact that the allegations were not disaggregated into complaints and abusive incidents. Such an approach would have led to a sharper focus on the safeguarding elements of the allegations and the potential for more timely reporting.

8.77 The extensive delay taken to complete relevant interviews compounded the time taken to produce the draft Ennis Report. From the dates available to the Review Team, interviews with MAH staff concluded on 15th May 2013. The draft report was then available for the strategy meeting convened on the 5th July 2013. At that time, one patient interview remained outstanding. In the opinion of the Review Team, all interviews should have taken place more proximate to the events which were the subject of the complaints in order to ensure that memories were fresh and that discussion over time had not coloured staff's perceptions of the issues being investigated.

8.78 The Review Team's opinion is that from the outset, the Ennis investigation should have considered whether the allegations were of an institutional abuse nature. The discussion at the last recorded case conference, nearly one year after receipt of the allegations, as to whether it was institutional abuse, remained unresolved at the end of that meeting. This lack of decision was unacceptable to the Review Team.

8.79 The failure to notify the HSC Board of the incident as an SAI, despite repeated requests from the HSC Board, was a missed opportunity to investigate the wider structural, staffing, and cultural issues within MAH. An SAI investigation had the potential to identify the nature of the issues which contributed to the allegations

made in November 2012 and to enable early remedial action to have been taken. It is conjecture to suggest that this might have prevented the events of 2017 captured on CCTV; but given that this was a potential outcome, the Review Team has not discounted this possibility.

8.80 The range of improvements in the environment, staffing, and care of patients during the Ennis investigation was considerable and did much to improve the ward as a living and working space. It is a matter of deep regret to the Review Team that the implementation of these changes came about only as a consequence of the harm caused to vulnerable patients. Our review of the records and discussion with staff confirm that the shortcomings in staffing, the ward environment, lack of access to a multidisciplinary team, and the conflicting needs of patients on the ward were known but not acted upon prior to the Ennis investigation.

Summary Comments and Findings

- **The Ennis investigation took an extensive period of time to complete which diluted its impact. The completed report was not brought to the attention of the Executive Team or the Trust Board.**
- **There was little evidence of multidisciplinary working in Ennis or patient activities. The absence of activities resulted in boredom, a lack of stimulation, and served to contribute to the management challenges of caring for patients with complex and at times conflicting needs.**
- **Nurse to patient ratio were low in Ennis. A staff ratio of 20:80 of nurses to healthcare assistants pertained at times. This compromised the ability of staff to provide safe and effective care for patients.**
- **Staffing difficulties were added to the MAH risk register as a serious Risk (red). This risk was not escalated further.**

- **The culture clash between staff who viewed the ward as a home and those who viewed it as a hospital resulted in tension between senior managers and ward managers and staff delivering care.**
- **The allegation should have been dealt with as an SAI. This would have ensured wider scrutiny.**
- **The Trust advised the HSC Board repeatedly that the safeguarding investigation was unable to substantiate the allegations, even though the Public Prosecution Service determined that in two cases the threshold for prosecution was met.**
- **The Review Team considered that the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards.**
- **One year after the report was completed the DO advised that she was proposing to update families. There is no evidence of feedback or the case having been closed.**
- **The DO's operational oversight into the day-to-day functioning of the Ennis ward served to weaken the focus on completing the investigation within an acceptable time frame.**
- **The tension between the DO and her line manager put the DO under pressure and led to imprecise conclusions in respect of the nature of the abuse.**
- **Positive changes were made to staffing and the environment in Ennis as a result of the Ennis investigation.**
- **The Review Team believed that not to have held an SAI investigation in respect of these allegations either in parallel or at the conclusion of the investigation constituted a missed opportunity to improve safeguarding**

arrangements for vulnerable patients.

- **There is no evidence of learning emerging from the safeguarding investigation as feedback was provided neither to staff, the Executive Team nor the Trust Board.**

ii. CCTV

8.81 The following section is divided into two sub-sections:

(i) a history of CCTV installation at MAH and the Assault on a Patient on 12th August;
(ii) the involvement of the PSNI; and
(iii) subsequent Trust handling of CCTV.

(i) A History of Implementation and the Assault on a Patient on 12th August

8.82 One of the first references that the Review Team could find regarding the installation of Closed-Circuit Television (CCTV) in the wards at MAH was in the minutes of the MAH Core Group meeting of August 2012. At that meeting the Senior Social Worker spoke of the 'amount of incidents involving patient on patient and patient on staff.' He suggested the installation of CCTV in communal day spaces, corridors, and quiet rooms. The Senior Manager Service Improvement and Governance manager agreed to look at existing policies around CCTV, check with the Directorate of Legal Service, and whether other Mental Health services used CCTV.

8.83 In 2013 a business case application was prepared by the MAH Clinical and Therapeutic Manager for the use of CCTV within the 'Core' hospital. The business case proposed that CCTV would be installed in communal areas used by patients and staff in Sixmile and Cranfield male, female, and Intensive Care wards. The overall purpose was: 'CCTV surveillance is required on the basis that they will make the hospital environment safe and secure for patients, staff and visitors. In 2012/13 there were 667 reported assaults to the PSNI from Muckamore Abbey Hospital.' Belfast Trust's Capital Evaluation Team approved a funding bid for the installation of internal CCTV in these wards at an estimated cost of £80k on 13th January 2014. This allocation was approved in principle by the Trust's Executive Team on the 22nd January 2014. In 2014 a detailed business case was prepared, led by the Business and Service Improvement Manager for Learning Disability Services.

8.84 Funding became available In the later part of the 2014/15 financial year. After the appropriate procurement processes concluded, contracts were awarded to architects, design consultants, and contractors to proceed with the installation of CCTV. Work on CCTV installation commenced in February 2015 in Cranfield, comprising Cranfield 1 and 2 and the Psychiatric Intensive Care Unit (PICU), and in the Sixmile wards. The Business and Service Improvement manager and the Clinical and Therapeutic manager from MAH were in contact with the contractors throughout the installation and commissioning processes.

8.85 On 21st April 2015 the contractors informed the Business and Service Improvement Manager that the CCTV had been installed in Cranfield and Sixmile wards and was now recording; a demonstration of the equipment was offered. The contractor explained the need for a period of recording prior to the demonstration to allow the full system's functions to be illustrated at the demonstration. At this time there was also discussion about the need to add additional cameras to cover

the gardens that were attached to each building. These additional cameras were added to the schedule of work.

8.86 The Service and Improvement Manager responded immediately suggesting that he be accompanied at the demonstration by the Operations/Nurse Manager and the Adult Safeguarding Officer. The contractor confirmed that the demonstration would take place on Wednesday 13th May 2015.

8.87 From the information provided by the contractor, the Review Team can summarise that the CCTV installation comprised the installation of large fixed cameras mounted in the public areas of the wards. The cameras were motion activated which meant that they were not in continuous record mode, which made it more practical to view playback. Cranfield and Sixmile wards each had their own CCTV recording systems which were in locked communication rooms. Each of the recorders had at least two screens to facilitate viewing. The recording arrangements provided for 120 days storage of the video footage. It is not clear from the specification whether the system was designed to overwrite recorded video after 120 days or whether 120 days was the minimum time for the storage of video. In the opinion of the Review Team it is highly likely that the system stored video beyond 120 days. This view is confirmed by a Trust briefing paper dated September 2018 which stated that: 'all available CCTV footage was preserved from 1st March 2017 until 30th September 2017'; a period of 184 days.

8.88 Records show that the CCTV project was commissioned and handed over to the Trust on 9th July 2015. It is not clear from the records examined who represented the Trust at the handover. Reference is made however to the need for the Business and Service Improvement Manager to be in attendance.

8.89 An examination of MAH Senior Nurse Meeting minutes shows that the introduction of CCTV to the wards had been the subject of discussion and consultation for

some time. The Senior Nurse Meeting was chaired by the Service Manager for the hospital. It was attended by the Ward Sisters/Charge Nurses for each ward and other senior nurses on the MAH site. In April 2014 there was reference in these minutes to a webcam presentation and the benefits it could bring. No other details are given about the proposals. In May 2014 the Service Manager stated that webcams would be installed on the wards. The Review Team concluded that the reference to the webcams was a reference to CCTV. In June 2104 the Service Manager told those attending that webcams had been ordered for all wards.

8.90 In May 2015 the MAH Safeguarding Officer reported that there had been a demonstration of CCTV and it had been shut down until policies were agreed to support its use. In June 2015 he stated that CCTV was still not operational. He added that they would be helpful for adult safeguarding. The Review Team asked the company responsible for the installation of the CCTV cameras when cameras started recording. The company responded that: 'recording started at handover.' Handover was at 9th July 2015.

8.91 In December 2015 the Trust entered into a contract with the CCTV contractor to provide routine servicing, callout, and repair of security systems in their community facilities which included MAH. The contractor confirmed that this contract included CCTV in MAH. The Trust was paying for this maintenance contract from December 2015.

8.92 From August 2015 until August 2017 mention was made at the Senior Nurse meetings about the drafting of CCTV policies and the consultation process for its operation. In August 2017 attendees of the meeting were told that the CCTV policy had been approved and would be rolled out in Cranfield and Sixmile wards on the 11th September 2017. The meeting heard that communications sessions were planned for staff and patients and signage would be going up. There was a delay of 25 months between the commissioning of the CCTV in May 2015 and the

Trust's decision to post signs about the cameras becoming operational in September 2017.

8.93 In June 2017 the Trust approved a policy (ref SG 09/17) for the implementation of CCTV within MAH. Its purpose was to assist with investigations related to adult safeguarding issues. The front page of that document shows that consultation and finalisation of the policy began in September 2015 and was not completed until June 2017. The pathway towards approval was as follows:

- 24 September 2015 - Initial Draft of the policy
- May 2016 - Amended after first round of consultation
- 11 August 2016 - Amended after 2nd round of consultations and approved by Clinical and Social Care Governance Committee
- 1 March 2017 - Approved by the Standards and Guidelines (Committee)
- June 2017 - Approved by the Trust Policy Committee
- 28 June 2017 - Approved by the Trust Executive Team.

The review team could find no evidence that the Executive Team queried why it had taken so long for the draft policy to reach it for its final approval.

8.94 The Review Team heard a number of different versions of what happened following approval of the policy. It has been difficult to be specific about a timeline from 28 June 2017 to the meeting between MAH managers and Mr. B, a complainant, in August 2017. Several managers from the Trust who are now retired and who had central roles to play in the implementation of CCTV did not meet with the review team.

8.95 It was agreed that the CCTV would go live from September 2017, probably 11th September. The Service Manager told the Review Team that work had to be completed on a Communications Strategy with staff in August before the system

went live. The complaint by Mr. B in August 2017 resulted in the discovery that CCTV had been recording for some time previously.

8.96 Mr. B., the father of a young man who was a patient in PICU ward, received a call from the Belfast Trust to inform him that his son had been physically assaulted by a member of staff. Mr. B. advised that he was notified on 21st August 2017, although Trust correspondence suggested this could have been 22nd August. Mr. B was told that the assault occurred on 12th August. Mr. B. told the Review Group that he immediately got into his car and drove to MAH to ascertain what had happened. He told the Review Team that he could not understand why it had taken 9 days to inform him of the incident; normally he would have been contacted on the day of any incident concerning his son.

8.97 Mr. B raised the issue of the assault with the RQIA on his way to a meeting at MAH on 25th August 2017. At the MAH meeting Mr. B met with the Operations Manager and the Safeguarding Officer who explained to him what had happened to his son. Mr. B was accompanied to this meeting, at his request, by a patient advocate from Bryson House. Mr. B did not accept the explanation provided. He inquired whether there was CCTV coverage of the incident. As a regular visitor to MAH since his son's admission in April 2017, Mr. B had noticed the presence of CCTV cameras on the ward. After the meeting he sent a formal complaint to the Belfast Trust. The complaint that Mr. B subsequently raised and how it was dealt with is an important aspect of this review and is dealt with in this report (see Paras 8.113 to 8.126).

8.98 The Manager informed Mr. B that the cameras were not recording. Mr. B challenged this response. He told the Review Team that he had observed CCTV notices on the walls of the hospital and had assumed that there must be CCTV coverage. He also informed the Review Team that prior to his son's admission to

MAH he had been given assurance in relation to his son's safety at MAH by the his son's social worker who told him that that the CCTV in MAH was operational.

8.99 The Belfast Trust sent an Early Alert about the assault on Mr. B's son on 8th September 2017 to the DoH and HSC Board. There was no reference to CCTV in the Early Alert. An update on the Early Alert was provided on 22nd September 2017 which stated that: 'CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of the CCTV footage.' This appears to be the first acknowledgement from Trust HQ that there was CCTV footage at MAH.

8.100 Almost all those who were interviewed from the Belfast Trust were asked about the CCTV. Why was it introduced? When did recording start? No one was able to tell the Review Team when recording started. The assumption by local MAH managers was that it would go live in September 2017 following the period of consultation with staff. At Director level the Review Team could not find any knowledge of how or when CCTV would be the introduced.

8.101 The Review sought to establish how managers at MAH became aware of the existence of historical CCTV recordings and when these were first viewed in relation to the events of 12th August 2017. The person with most knowledge about the CCTV, the Business and Service Improvement Manager who is now retired did not communicate with the Trust or the Review Team. It is difficult, therefore, to establish a precise timeline.

8.102 When the Service Manager for MAH was interviewed she recalled that she was told by the Business and Service Improvement Manager two days after the meeting with Mr. B at MAH that there might be CCTV footage of the incident that occurred on 12th August. The Review Team concluded that the Business and Service Improvement Manager's comment was prompted by Mr. B's challenge

regarding whether CCTV was recording. It is evident that some senior managers at MAH must have viewed some of the historic CCTV footage as Trust records show that legal advice from the Directorate of Legal Services (DLS) was sought on the 4th September to clarify if they could 'view the footage as part of an investigation'. The DLS replied on 19th September 2019 that the recording could be viewed. The Review Team has no doubt that some senior managers at MAH viewed some of the historic recording in late August/early September 2017. The information about its the contents was not however, provided to a Trust Director until 20th September.

8.103 The Service Manager told the Review Team that she viewed the recordings on 20th September and immediately phoned the Trust's Director of Nursing to inform her of the content. The Director of Nursing advised her to phone the Chief Nursing Officer at the DoH to inform her of these matters. The CNO was advised the next day. The Trust subsequently submitted an SAI notification to the DoH and the HSCB on 22nd September 2017.

8.104 The Service Manager told the Review Team that she wanted to raise an SAI as soon as she heard about the assault on Mr. B's son. She completed an SAI form on the 1st September 2017 which was returned to her by the Learning and Disability Directorate's Governance department. She stated that she was dissuaded from pursuing an SAI by the Co-Director Learning Disability Services as it did not meet the criteria for an SAI.

8.105 The complaint that Mr. B subsequently raised and how it was dealt with was an important aspect of this review; it is dealt with further at par. 8.113 – 8.126 below.

(ii) The Involvement of the PSNI

8.106 The PSNI were alerted to the allegations of assault on Mr. B's son on 22nd August 2017 under the Trust's Adult Safeguarding Policy and the Joint Protocol. The PSNI became aware of the existence of historic CCTV recordings by mid-September 2017, when notified of this by the Service Manager at MAH. Initially the police worked with the Trust and the RQIA under the Joint Protocol procedures. The police was not informed of the volume of CCTV footage that had been recorded until significantly later in the viewing process. The Review Team was told by the PSNI that due to frustration with the manner in which the Trust was handling the CCTV in February 2019 they seized the recordings. It eventually emerged that there was more than 300,000 hours of recording from CCTV in MAH.

8.107 The PSNI set up a large team to scrutinise the recordings, the largest team ever assembled for such work in Northern Ireland. The CCTV recordings viewed by the PSNI dated back to March 2017. There is no explanation as to why there was six months of CCTV footage when the specification for the retention of CCTV stated that footage would be retained for 120 days before being overwritten (see Para 8.87).

8.108 In 2019 the PSNI expressed concern about the presence in the investigation of the former Business Service Improvement Manager for MAH who had retired but had been brought back by the Trust on a temporary basis to look after CCTV cameras and security on the site. The Trust terminated this arrangement. The Review Team emphasises that there is no suggestion of impropriety in respect of this individual. The Review Team tried to speak to this retiree through the Belfast HSC Trust. He did not acknowledge any of the communication sent to him.

8.109 When asked about the level of co-operation they had received from staff in the Belfast HSC Trust, the police said it was mixed. The police seized the CCTV

recordings. Copies were however returned to the Trust to enable it to recommence viewing of the footage.

8.110 At the time of writing the PSNI had not yet completed viewing all of the historic recordings. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions. Sixty-two staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV.

(iii) Subsequent Trust handling of the historic CCTV recording

8.111 In a written report to the Trust Board in January 2018 the Director of Adult and Social Care reported that work was underway to install CCTV in the remaining wards at MAH and the swimming pool on the site. She went on to state that the team that was set up to view the historical CCTV had viewed 25% of the footage. This was inaccurate. It is clear that the Trust had still not grasped the enormity of the CCTV recordings that still had to be viewed.

8.112 By September 2018 a team of ten external viewers working five days a week were employed by the Trust to carry out retrospective viewing of CCTV. The Director of Adult and Social Care told the Trust Board on 6th September 2018 that the viewing of PICU footage would be completed by early September and that the remaining three wards (Cranfield I and 2 and Sixmile) would be completed by the end of September. The same Director reported to the Board in February 2019 that viewing was still not complete with an estimated 20% yet to be watched. Senior staff in the Belfast Trust consistently underestimated the task of viewing the retrospective recordings. This partially accounted for the PSNI's frustration about the Trust's approach which resulted in recordings being seized and taken off site.

Summary Comments and Findings

- **Evidence points to CCTV recording since July 2015.**
- **The Trust was paying a maintenance contract for a system that they had installed but did not make use of for over two years.**
- **It took 22 months, an inexplicably long time, to produce a policy to implement CCTV in MAH. Most of the delay was at local level where the Business and Service Improvement Manager was the lead.**
- **Had CCTV been operationalised earlier, harm to patients may have been prevented.**
- **It is the Review Team's view that had Mr. B not queried CCTV recording and persisted with his enquiries it is likely that the scale of historical CCTV would not have been discovered.**
- **There was an unacceptable delay in bringing matters to the attention of the HSC Board and the DOH despite the situation being known to senior managers on the MAH site. It was not escalated off the MAH site for two or three weeks after footage came to light.**
- **The Trust Board consistently failed in 2017 and 2018 to identify the scale of CCTV footage as the information provided to it was incomplete and at times inaccurate.**
- **The Review Team is critical of the reaction of the Co-Director of Learning and Disability Services in resisting the suggestion to raise an SAI. It formed the view that this was an attempt to contain the matter**

within the MAH management team. This manager declined to meet with the Review Team. In the absence of an account from this staff member the Review Team is content to accept the account of the Service Manager.

iii. Mr. B's Complaint – August 2017

8.113 On 21st August Mr. B was advised that on 12th August 2017 his son, AB, had been the victim of an assault by a member of staff. Mr. B was concerned that it had taken nine days to advise him of the assault on his son, particularly as he was used to having early alerts regarding his son's behaviour since his admission to PICU in April 2017. Mr. B was understandably concerned about the delay and not unnaturally was fearful that the delay was to enable any bruising on his son to fade.

8.114 The Review Team examined a range of documentation and interviewed senior staff at MAH and Trust Board levels in an attempt to ascertain the events around the assault on Mr. B's son and the reason for the delay in bringing matters to the attention of parents, safeguarding staff, and the Co-Director of Learning and Disability services.

8.115 A timeline in respect of Mr. B's complaint was developed by the Review Team (see Appendix 8). The Review Team identified no duplicitous or surreptitious reason for the delay in notifying Mr. B about the assault on his son, AB. The incident of 12th August 2017 was immediately reported by the staff nurse who witnessed it to the Nurse in Charge. Thereafter, there was a failure to comply with the Trust's Safeguarding policy and procedures.

8.116 It was not acceptable for the Nurse in Charge to have emailed the Deputy Charge Nurse (DCN) requesting a meeting to discuss a concern. This caused delay in reporting an assault on a vulnerable patient and prevented the establishment of a protection plan for AB and others on the ward.

8.117 The delay was further compounded as the requested meeting with the DCN did not take place until 17th August. The DCN considered the information provided about the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN therefore emailed him, requesting more details about the incident. This caused further delay in invoking the Trust's adult safeguarding procedures. The incident was not escalated at that time to senior managers within MAH nor was advice sought from MAH social work staff who carried safeguarding responsibilities within the hospital.

8.118 On 20th August 2017 the DCN received a further allegation in respect of the healthcare support worker involved in the incident with AB on 12th August. This allegation was of verbal abuse of a patient. The DCN then emailed the Charge Nurse seeking advice. On the Charge Nurse's return from leave, immediate and appropriate actions were taken in respect of both allegations made in respect of the healthcare support worker (see Appendix 8 for details).

8.119 The Review Team understands Mr. B's reaction to such information being provided to him nine days after the incident. The delay has done much to undermine Mr. B's confidence in the Trust. The handling of his requests for information and details about the CCTV in PICU and his complaint to the Trust has further diminished his lack of confidence in the Trust's managers and processes.

8.120 The handling of Mr. B's subsequent requests for information about his son's care and details about the CCTV in PICU also further eroded his confidence in the

Trust's management. Mr. B resorted to his Member of Parliament and the Information Commissioner in an effort to resolve matters to his satisfaction. The Review Team considered that more responsiveness to Mr. B's requests, with due regard given to the data protection rights of others who may have appeared on the recordings, would have been appropriate.

8.121 Mr. B met with MAH's Operations Manager and a Safeguarding Officer on 25th August 2017, as arranged by him on 21st August 2017 following notification of the assault on his son. To ensure he had support, Mr. B arranged for an advocate to accompany him. At that meeting Mr. B asked about the potential for CCTV footage in respect of the assault in respect of his son. He was advised that the CCTV was not yet operational and would be going live on the 11th September 2017. Mr. B, whose work involves the use of CCTV cameras in an institutional setting, did not accept the information provided. He stated that since his son was admitted to PICU he had seen signage advising that the ward was covered by CCTV. Mr. B subsequently attempted to acquire details about when the CCTV was operational.

8.122 The Review Team appreciated that the absence of information must have caused Mr. B considerable frustration. The Review Team, as already stated (see Paras 8.81 to 8.112), experienced considerable difficulties tracking down the information that Mr. B sought about the installation and operation of CCTV at PICU. The Review Team did not have the benefit of information from the Business and Service Improvement Manager at MAH, now retired, who it considered the individual most likely to have intimate detail of the CCTV system from the initial concept during 2012, through to the approval of the business case, and the system eventually being installed in July 2015. The Review Team considered it unacceptable for information about the operation of the CCTV system not to have been provided to Mr. B. The Review Team concluded that the CCTV was operating from July 2015.

8.123 Immediately following the meeting of 25th August, Mr. B emailed a complaint to the Trust in respect of his son's care. As he received no acknowledgement of his email, he contacted the HSC Board on the 29th August enquiring about when he could expect a response. It transpired that the original email had been sent to an 'incorrect' email address within the Trust. Once the Trust located the email on the 29th August it took immediate action through its Complaints Department with MAH's Governance Department.

8.124 From the exchange of emails between the Complaints and the Governance Departments, the Review Team identified two distinct approaches to how Mr. B's complaint would be handled. The Governance Department's view was that as the matter was of a safeguarding nature, it was not a complaint. The Complaints Department correctly interpreted the safeguarding and complaints policies by recognising that the safeguarding investigation would conclude at which stage, 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009).'

8.125 The Complaints Department's letter to Mr. B dated 30th August 2017 confirmed to him that his complaint could be addressed at the conclusion of the safeguarding investigation. The independent external Stage 3 SAI investigation commenced in January 2018 and reported in November 2018 in the *A Way to Go* report. There is no information in the documentation examined by the Review Team that Mr. B received individualised updates on the progress of the independent review. There was no information showing that Mr. B was contacted at the conclusion of the safeguarding investigation to ascertain if there were outstanding matters from his complaint which he wished to pursue further. The Review Team considered that best practice would have dictated that Mr. B be afforded an opportunity to pursue his complaint further from November 2018.

8.126 As matters currently stand, there is no resolution of Mr. B's complaint. The Review Team considered that the omission of the Complaints Department in this regard was unhelpful and did not conform with the assurance provided to Mr. B in its letter to him dated 30th August 2017.

Summary Comments and Findings

- **There was no deception associated with the delay in notifying Mr. B of the assault on his son, AB.**
- **There were breaches in compliance with Trust's reporting arrangements under the adult safeguarding procedures.**
- **Immediately the matter came to the attention of the Charge Nurse timely and appropriate responses were instigated informed by the Trust's adult safeguarding procedures.**
- **Mr. B's requests for information were not responded to in a timely or inclusive manner guided by the requirements either of Data Protection arrangements or the police investigations.**
- **Mr. B asked relevant questions about CCTV. At that time the Business and Service Improvement Manager was still employed at MAH. This retiree did not respond to requests to meet with the Review Team and it has no information about his recollections.**
- **Once Mr. B's emailed complaint was located within the Trust he received a timely response. The commitment to address any outstanding issues at the conclusion of the safeguarding investigation**

has not yet been honoured. The complaint remains open until closure is brought to the process.

- **The persistence of Mr. B in respect of the CCTV was significant. It is noteworthy that at the end of August, MAH wrote to the Department of Legal Services seeking legal advice on the use of CCTV footage. The Review Team was unable to ascertain whether at that time some MAH staff had identified that footage relating to the assault on AB was available (see Appendix 8).**

- **The involvement of Mr. B with a range of agencies including his MP may not have been required had the Trust shown more willingness to engage with him, and to share relevant information appropriately.**

- **The Trust Board was not provided with information about the existence of CCTV footage until 20th September 2017. The failure to escalate information to the Trust Board earlier was unacceptable professionally and managerially.**

9. Best Practice

9.1 The Review Team had planned to visit a number of centres of excellence to inform and develop recommendations. The lockdown caused by the Covid-19 pandemic necessitated a change of plans in this respect. The Review Team, therefore, has conducted a literature review which it considers pertinent to best practice developments.

9.2 Joe Powell, the CEO of All Wales People First which refers to itself as, the united self advocacy group for advocacy groups and people with learning disabilities in Wales, stated in the Foreword to the *Improving Care Improving, Lives* report, 'that we still deem it acceptable to house some people with learning disabilities within the hospital system, when it is no longer appropriate. If this situation is not remedied, we cannot truly claim that we have eradicated the unjust and deficit-centred culture of the long-stay institutions of the past.'[82] The Review Team was particularly struck by Powell's comments relating to 'the unjust and deficit-centred culture' as it underscored for Team members the need for a human rights based, patient-centred approach to planning with and for learning disabled patients. The Review Team regrets that due to the lockdown situation it was not in a position to meet more patients and their relatives and carers to assist in completing this review. We apologise that greater engagement was not possible. The Review Team will however, in its review of the literature, pay particular attention to the voice of service users and their families and carers.

9.3 As the history of MAH shows (Section 5), considerable change has occurred since it first opened its doors in 1949. A large institution caring for adults and children with at one time a maximum of some 1,400 inpatients, now cares for fewer than 60 patients. The resettlement agenda has placed considerable pressure on relatives,

[82] Improving Care, Improving Lives February 2020 https://gov.wales/sites/default/files/publications/2020-03/national-care-review-of-learning-disabilities-hospital-inpatient-provision.pdf

some of whom were anxious about their loved one's leaving the 'home' they had lived in for decades. Some staff also had anxieties as to their own future employment as the number of wards continued to reduce at the hospital. The Review Team heard evidence from one parent about the enhanced quality of care afforded to his son since he was provided with a tailored community care package.

9.4 The Review Team in the following discussion articulates principles which it believes will better meet the assessment and treatment of people with learning disabilities as well as informing the required community infrastructure and supports. The *Improving Care, Improving Lives* report made 70 recommendations targeted at: providers (35 recommendations); commissioners (33 recommendations) and the Welsh Government (2 recommendations). This was a more extensive review of learning disability services than the current review. The key learning from it which the Review Team considered relevant to MAH are summarised below:

- 'patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient. Detained patients should be aware of their rights';

- 'hospital support plans are reviewed regularly, within a maximum time period of three months. All care plans and hospital support plans are developed with specific objectives, measurable outcomes and clear timescales';

- 'a safe, effective, and therapeutic environment of care, [is in place] in order to reduce frustration and boredom which could lead to behaviours that challenge.. [S]taff are trained to recognise escalating behaviours and to deliver positive and preventative interventions. ... [A]ll patients have a plan in place identifying the outcomes to be achieved in order to transition to the next step on their care journey';

- ‘any restrictive intervention involves the minimum degree of force, for the briefest amount of time, and with due consideration of the self-respect, dignity, privacy, cultural values, and individual needs of the patient. A restraint reduction plan [should be] in place for each patient’;

- ‘patients, families, and carers have a voice in service design.... [M]easures of patient satisfaction are obtained and used as indicators of responsive and quality services’;

- ‘Commissioners ensure a sufficient level of staffing to provide safe and progressive care’;

- ‘Commissioners should consider investment in early intervention and admission prevention community services.’

9.5 In 2015 NICE published guidelines titled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges’[83] The guidelines, which have been endorsed in Northern Ireland by the Department of Health, ‘cover intervention and support for … adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and interventions for family members and carers.’ The general principles which underpin the Nice Guideline include:

1. ‘Working in partnership with … adults who have a learning disability and behaviour that challenges, and their family members of carers, and:

[83] https://www.nice.org.uk/guidance/ng11

- involve them in decisions about their care;
- support self-management and encourage the person to be independent;
- build and maintain a continuing, trusting, and non-judgmental relationship;
- provide information:
  - about the nature of the person's needs, and the range of interventions … and services available to them;
  - in a format and language appropriate to the person's cognitive and developmental level…;
- develop a shared understanding about the function of the behaviour;
- help family members and carers to provide the level of support they feel able to.

2. When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members of carers:
   - take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems;
   - aim to provide support and interventions:
     - in the least restrictive setting, such as the person's home, or as close to their home as possible; and
     - in other places where the person regularly spends time….;

- aim to prevent, reduce, or stop the development of future episodes of behaviour that challenges;
- aim to improve quality of life;
- offer support and interventions respectfully;
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person;
- ensure that they know who to contact if they are concerned about care or interventions…;
- offer independent advocacy to the person and to their family members or carers.

3. Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour challenges … should understand:

    - the nature and development of learning disabilities;
    - personal and environmental factors related to the development and maintenance of behaviour challenges;
    - that behavioural challenges often indicate an unmet need;
    - the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational, and occupational functioning;
    - the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

4. Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

5. If initial assessment … and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams … have prompt and coordinated access to specialist assessment, support, and intervention services.…

6. Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges.

7. Health and social care provider organisations should ensure that all staff get personal and emotional support ….

8. Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff.…

9. A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers, and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services. …

10. The designated leadership team should be responsible for developing, managing, and evaluating care pathways, …

11. The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

12. The designated leadership team should work together to design care pathways that respond promptly and effectively to the changing needs of the people they serve, …

13. The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services …

14. The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information …

15. GPs should offer an annual physical health check to … adults with a learning disability in all settings, using a standardised template… This should be carried out together with a family member, carer, or healthcare professional or social care practitioner who knows the person …

16. Involve family members or carers in developing the support and intervention plan for … adults with a learning disability and behaviour challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public.' …

17. When assessing behaviour that challenges shown by … adults with a learning disability, follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. …

18. Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer, or advocate to support the person and help them to understand the feedback if needed.

19. If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services…

20. Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions …

21. Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach, …

22. Develop a written behaviour support plan for … adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour.

23. Consider personalised interventions for … adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time.

24. Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or

carers to be involved in planning and reviewing reactive strategies whenever possible.

25. Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and the need for restrictive interventions.'

9.6 The NICE guideline address the range of issues found by the Review Team in relation to: staffing levels and skills; the availability of safe, effective and compassionate care; the absence of behavioural support services resulting in over-use of restraint, seclusion and physical interventions with patients; the effectiveness of care planning and transition arrangements for patients; and the poorly developed multidisciplinary approach to patient care.

9.7 The use of seclusion and physical interventions with patients has been commented on throughout this report. Best practice in working with learning disabled patients who presented with aggressive and/or challenging behaviours did not underpin strategies relating to their management at MAH. Future practice in these areas was considered by the Review Team in terms of:

- RCN Advice issues in 2017, which is scheduled to be reviewed in 2020, which adopted a rights based approach to consideration and review of restrictive practices.[84] It states that, 'restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practices is therapeutic, ethical, and lawful.' It also acknowledges the benefit of early interventions

[84] [84] Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions, RCN, 2017 https://www.rcn.org.uk/professional-development/publications/pub-006075

and an understanding of the cause of such behaviours. The rights-based approach is seen as a means of placing the person at the centre of care;

- HM Government guidance of 2019 on reducing the need for restraint and restrictive practices[85] is directed at children and young people. The recognition in it of the traumatising effect of restrictive practices on children, young people, families, and carers, and the potential for long-term consequences for health and wellbeing are messages which are also relevant to adults. The core values, and principles upon which the guidance is based are also pertinent to adults:

  - 'uphold children and young people's rights;
  - treat children and young people with learning disabilities … as full and valued members of the community whose views and preferences matter;
  - respect and invest in family carers as partners in the development and provision of support; and
  - recognise that all professionals and services have a responsibility to work together to coordinate support …'

  In regard to restraint, the values stated:

  - 'every child or young person deserves to be understood and supported as an individual;

[85] Reducing the Need for Restraint and Restrictive Interventions HM Government, 27 June 2019 https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention

- the best interests of children and young people and their safety and welfare should underpin any use of restraint;

- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people… should be considered and balanced with the needs and circumstances of others….; and;
- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned,' …[86]

- The Mental Welfare Commission for Scotland in 2019 issued a good practice guide to inform the use of seclusion. The purpose of the guide 'is to provide clear guidelines for the consideration and use of seclusion and to ensure that, where this takes place, the safety, rights and welfare of the individual are safeguarded.'[87]

9.8 NICE has also developed a number of guidelines and quality standards specific to individuals with challenging behaviours and learning interventions. In developing inpatient and community care services for such individuals, the Review Team considered that the following literature should be used to inform a service model in Northern Ireland:

- Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges;[88]

- Learning disabilities: challenging behaviour;[89]

[86] Ibid, Pages 17 - 19
[87] Use of Seclusion: Good Practice Guide, Mental Welfare Commission for Scotland, October 2019, Page 5 https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf
[88] Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline, 29 May 2015 nice.org.uk/guidance/ng11

- Mental health problems in people with learning disabilities: prevention, assessment and management;[90]

- Learning disabilities: identifying and managing mental health problems;[91]

- Learning disabilities and behaviour that challenges: service design and delivery.[92]

9.9 A selected range of other resources which Commissioners and Providers of services for individuals with learning disabilities may find informative are listed below with links to the publication for reference purposes:

- Royal College of Psychiatry

  - People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services;[93]
  - Enabling people with mild intellectual disability and mental health problems to access health care services;[94]
  - Care Pathways for people with intellectual disability;[95]
  - Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results;[96]

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[89] Learning Disabilities: challenging behaviours Quality standard, 8 October 2015, nice.org.uk/guidance/qs101

[90] Mental health problems in people with learning disabilities: prevention, assessment and treatment, NICE guideline 14 September 2016, nice.org.uk/guidance/ng54

[91] Learning disabilities: identifying and managing mental health problems, Quality standard 10 January 2017 nice.org.uk/guidance/qs142

[92] Learning disabilities and behaviour that challenges: service design and delivery, NICE guideline, March 2018, nice.org.uk/guidance/ng93

[93] People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services, July 2013 https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf?sfvrsn=cbbf8b72_2

[94] Enabling people with mild intellectual disability and mental health problems to access health care services, November 2012 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr175.pdf?sfvrsn=3d2e3ade_2

[95] Care Pathways for people with intellectual disability, September 2014, https://rcpsych.itinerislive.co.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-05.pdf?sfvrsn=11e73693_2

- Standards for adult inpatient learning disability services;[97]

- The Joint Commissioning Panel for Mental Heath's guidance for commissioners of mental health services for people with learning disabilities;[98]

- Local Government Association, ADASS (adult services), and NHS England publication: Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition;[99]

- The National Quality Board publication: An improvement resource for learning disability services: Safe, sustainable and productive staffing:[100];

- British Journal of Psychiatry article: Impact of the physical environment of psychiatric wards on the use of seclusion;[101]

- Journal article: Evaluation of seclusion and restraint reduction programs in mental health: A systematic review.[102]

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[96] Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results, 2015, https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-06.pdf?sfvrsn=5a230b9c_2

[97] Standards for adult inpatient learning disability services, July 2016 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-standards-3rd-edition-2016.pdf?sfvrsn=b181aa51_2

[98] The Joint Commissioning Panel for Mental Heath, Guidance for commissioners of mental health services for people with learning disabilities, May 2013, https://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf

[99] Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, October 2015, https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

[100] Safe, sustainable and productive staffing: An improvement resource for learning disability services, January 2018 https://improvement.nhs.uk/documents/588/LD_safe_staffing20171031_proofed.pdf

[101] Schaaf van der P.S. et al Impact of the physical environment of psychiatric wards on the use of seclusion, 2013. 202, 142 – 149, https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/impact-of-the-physical-environment-of-psychiatric-wards-on-the-use-of-seclusion/ECF01A965156AF94A632E8436F13FD9D

[102] Goulet M-H, et al, Aggression and Behavior, 34 (2017) Pages 139 – 146 Evaluation of seclusion and restraint reduction programs in mental health: A systematic review https://www.sciencedirect.com/science/article/abs/pii/S1359178917300320

9.10 The future model of inpatient services for individuals with a learning disability requires that best practice guidance, standards, and models are considered and developed to inform a modern, person-centred, rights driven service approach. This review found that dysfunctional management and a lack of a shared vision impacted negatively on patient care. The initiatives taken by the Trust to engage patients, carers, and families in care planning and the oversight arrangements within MAH require further development to ensure that meaningful engagement can be maintained and promoted.

9.11 The *A Way to Go* Report stated that 'the CCTV has given the Hospital a decisive edge. Visual evidence of assaults endured by patients who cannot describe what has happened was an impetus for the crisis management response.' [103] In the future, CCTV needs to be considered as a tool to prevent harm to patients rather than a means to ensure safe and compassionate care.

9.12 Finally, the above list of available materials has been selected in order to help inform a future commissioning and delivery agenda which promotes respect, dignity, care, and compassion for individuals with learning disabilities who are among some of society's most vulnerable citizens.

Summary

- Providing safe, effective, and compassionate care requires sufficient staff, with appropriate skills and ongoing access to training and professional development if it is to be more than a meaningless mantra.

- Services must be patient-centred informed by individualised assessment, planning and review processes to develop tailored care, protection, and

[103] Op. Cit par. 52, Page 18

transition plans for each patient.

- Patients, their families, and carers should be actively involved in decision making and in developing approaches to address behavioural or safeguarding concerns.

- Transition planning requires the active engagement of the patient, family/carers, and community support services to plan for a phased transition to life outside the hospital.

- The culture in the hospital should respect and promote patients' rights under the European Convention on Human Rights (ECHR).

- Advocacy services and family/carers and patients should regularly be asked to provide feedback on the standard and quality of care provided.

- All restrictive practices should be a last resort and used for the least time possible to comply with Article 5 of the ECHR (the Right to Liberty and Security).

- Locked doors for patients who are not detained under the provisions of the Mental Health Order are likely in to be in breach of Article 5 and such practices should be reviewed by the Trust to ensure compliance with legislative requirements.

- CCTV is an important tool in preventing abuse, however, it cannot be relied upon to ensure a culture of compassionate care.

- Clinical Leadership is essential for the promotion of patient safety and service quality.

- Multidisciplinary working and a strong leadership team are essential to the future provision of inpatient services for learning disability patients.
- An infrastructure of community support services is required to obviate, where possible, inappropriate admissions to hospital and to ensure that discharged patients' placements are well supported and sustained.
- Hospital as a permanent home for patients' capable of living in the community is no longer an option and every effort should be made to ensure phased, planned, and well supported discharges occur for patients who are inappropriately cared for within a hospital setting.
- Greater focus is required to working together with patients, relatives, carers, and community resources to ensure that in the future MAH is no longer a place apart.

10. Conclusions and Recommendations

10.1 The Review Team concluded that:

1. The Trust, given its size and scale, had extensive governance systems in place:

   - the complexity of its governance systems hindered its agility and ability to be responsive;

   - any system is dependent on those who implemented it, therefore in itself it cannot provide assurance;

   - changes of senior management arrangements and titles resulted in confusion for front line staff, some of whom were unclear of arrangements which existed in the Trust in respect of MAH;

   - the governance system became a tick box exercise at MAH;

   - the Trust as an organisation championed practice development and quality improvement, as well as safer patient initiatives. There was however, limited evidence of how it influenced patient care at MAH;

   - the SAI group was stood down in 2013 as a stand-alone Committee of the Trust Board. The Review Team was unable to ascertain to what degree, if any, this may have impacted on the priority given to adherence with SAI procedures or feedback to the Executive Team or Trust Board;

   - there was a lack of escalation of issues from MAH to the Executive Team of the Trust Board. No issues regarding MAH were escalated to the Trust

Board or Executive Team between 2012 and 2017 despite its ongoing difficulties in relation to staff recruitment and retention;

- an extensive array of policies and procedures existed within the Trust. An external review of a number of policies and procedures relating to seclusion and restraint found the extant policies were out of date and that more recent best practice developments had not been taken into account;

- In 2005 the Department issued in draft form its Guidance on the use of Seclusion and Restraint. The Review Team knows that this Guidance was used to inform the Southern HSC Trust's policies in these areas. As the 2005 draft consisted of extensive guidance on monitoring arrangements, it is unfortunate that the Draft Guidance was not issued in final form by the Department as it had, through its monitoring mechanism, provided an opportunity to highlight and remedy excessive use of physical interventions.

- there was limited evidence of Executive or Board engagement with MAH prior to the events identified in August 2017. Walkabouts scheduled for all Trust facilities in 2012 did not result in a site visit to MAH until 2016.

2. Discharge of Statutory Function (DSF) Reports were provided annually by the Trust to the HSC Board:

   – these were largely repetitive documents which did not provide assurance neither in relation to the discharge of Statutory Functions, nor to the standard of practice in relation to same;

   - there was no reference to the Ennis investigation within the DSF Reports;

- there was insufficient challenge from the Trust Board and the HSC Board in relation to DSF Reports. Feedback provided to the Trust from the HSC Board related to failings in meeting resettlement targets;

- there was a recognition that the reporting format was leading to repetitive reports which lacked outcome data. Despite this, the reporting structure was not amended.

3. There was limited evidence of multidisciplinary working at MAH:

- nurses, including healthcare assistants, were for operational purposes the key workforce on site;

- there was evidence of nurses feeling unsupported by medical staff;

- there were ongoing problems relating to the identification and diagnoses of physical healthcare needs of patients which were not addressed until a service was procured from a local GP's practice;

- there was insufficient multidisciplinary team working with patients across the MAH site;

- the general absence of behavioural support staff, in particular psychologists, had a detrimental impact on patient care and contributed to challenging behaviours.

4. Failure to use data and learn from it:

   - information regarding physical interventions, restraint, vulnerable adults, and seclusion were regularly presented to Governance and Core Group meetings at MAH. There is no evidence of data being analysed or triangulated to inform practice, staff learning, or the workforce strategy. There was also no evidence of trends being analysed;

   - information from RQIA inspection reports was not used proactively to develop staff or improve patient care;

   - RQIA had no joined up approach to inspecting wards at MAH but neither had the Trust a joined up approach to identifying trends from such reports or in learning from the Iveagh Report where it had relevance to the adult hospital sector.

   - there was evidence that priority was afforded to completing information returns rather than learning from them;

   - there was limited evidence of how patients' and carers/relatives' views were sought and used to inform patient care.

5. There were staffing difficulties in MAH particularly relating to nursing and Consultant posts:

   - inadequate nursing staff resulted in a heavy reliance on bank and agency staff which resulted in a skill mix ratio of nurses to healthcare assistants which at times was as low as 20:80 on wards. There was an absence of

clinical oversight of practice, particularly of healthcare assistant level on a 24/7 basis;

- the staffing difficulties were hindered by the moratorium on posts compounded by the lack of a workforce strategy;

- there was limited investment in staff training and development activity, with a focus on mandatory training. There was little evidence based upon: therapeutic education; education and development; or national strategies promoting reductions in seclusion and promoting behavioural support;

- wards were closed prematurely to cope with staffing shortages. Insufficient attention was afforded to the impact this would have on patients or the skill mix of staff;

- patient activities were restricted due to staffing deficits which resulted in boredom and heightened levels of challenging behaviours;

- medical staff were at times not available in sufficient numbers to support nursing staff or to drive up standards within wards;

- nursing workforce shortages were not escalated within the Trust or to the Department.

6. The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost:

- the physical environment in wards scheduled for closure was allowed to deteriorate, resulting in a living and work environment not conducive to high standards of practice;

- relatives/carers of patients and hospital staff's anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients' transition to care in the community;

- there was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community.

7. MAH had its own culture which was not informed by the leadership values of its parent organisation:

- the Trust had its values set out in *The Belfast Way* and in a range of other documents. There was no evidence that these had been cascaded successfully to staff at MAH;

- there was a culture clash within MAH between those who viewed it as a home for patients rather than a hospital with treatment and assessment functions;

- staff were more focused on maintaining the status quo at MAH rather than adopting the values of the Trust. The *A Way to Go* Report commented on the loyalties which existed within the staff team to each other rather than to their employer;

- there was a practice in MAH of keeping issues and their management on-site. Evidence of this is found in the failure to bring the Ennis investigation and subsequent report to Trust Board. Similarly, by dealing with it solely as a safeguarding issue, it meant that it could be addressed on-site;

- the HSC Board repeatedly sought an SAI in respect of Ennis from 2012 to 2015. This request was never implemented by the Trust which eventually accepted that it was in breach of the SAI procedures. The admission of breach was not brought to Trust Board level by Trust personnel or the HSC Board;

- the Review Team was unable to ascertain why Ennis had not been escalated to Trust Board or the Executive Team by the Governance Lead or the Co-Director of Disability and Learning Services or the Directors of Nursing and Adult Social Care;

- an absence of visible leadership from Trust Board and Directors which resulted in MAH being viewed as a place apart.

Recommendations

10.2 In making recommendations the Review Team has considered actions taken by Belfast HSC Trust since 2017 to ensure safe, effective, and compassionate care in MAH. To avoid repetition recommendations are not made where action has already been taken. The following recommendations are made to assist the Department, the HSC Board/PHA, and the Trust to enhance the care provided to learning disabled citizens in a manner which builds on their strengths and supports them to reach their fullest potential.

The Department of Health

1. The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.

2. The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.

3. The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.

The HSC Board/PHA

1. The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.

2. Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.

3. Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.

The Belfast HSC Trust

1. The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.

2. The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust

considers sustaining these arrangements pending the wider Departmental review of MAH services.

3. Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

4. The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.

5. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

6. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

11. Acknowledgements

11.1 The Review Team wishes to thank all those who gave so generously of their time to meet with it. Without the assistance of parents, carers, advocates, past and present staff of the Department, HSC Board/PHA and the Trust, and RQIA, the PSNI, political representatives (MP and Health Minister) and the PCC the Review Team’s task would have lacked both depth and insight. The Review Team also benefited greatly from input from one of the Professional Nursing Officer at the Department of Health in relation to best practice guidance.

11.2 The Review Team benefited from a site visit to MAH in February 2020 when it had the opportunity to meet with staff and patients. Due to the Covid-19 situation it was regrettably not possible for the Review Team to make further contact with patients and a wider number of relatives and carers.

11.3 The HSC Leadership Centre provided accommodation and technical support for the Review Team which was much appreciated.

11.4 Considerable documentary evidence was provided by the Department and the Trust. The Review Team wishes to thank those staff who supported it so ably by the timely provision of requested documentation.

Appendix 1

Terms of Reference - A Review of Leadership and Governance at Muckamore Abbey Hospital

Background

A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital (November 2018) is the report from the Independent Serious Adverse Incident Review of Adult Safeguarding incidents occurring at Muckamore Abbey Hospital between 2012 and 2017. Belfast Health & Social Care Trust (BHSCT) has commenced work on an action plan to improve the care, safety, and quality of life for patients in the hospital, and the Department of Health have developed an action plan to address the regional and strategic issues identified in the report. The three Trusts whose populations use Muckamore Abbey Hospital are also prioritising work to facilitate the discharge of people who no longer require inpatient care.

It is felt that the review did not fully explore the leadership and governance issues in the hospital. Therefore, the Independent Review of Leadership and Governance at Muckamore Abbey Hospital is being commissioned to address any leadership and governance issues that may have contributed to safeguarding deficits in the hospital.

A timeline for completion of the review will be agreed at the first meeting with the review team and HSCB/PHA lead officers.

Methodology

The Review team seek to establish lines of communications with all the organisations that are impacted by this review. The Belfast HSC Trust will be the main focus of the review, but other organisations may include the RQIA, other Trusts, as well as families and carers. The DoH will also be approached to ascertain what policies were in operation during that time period that would be relevant to the issues of leadership and governance. The HSCB/PHA will inform these parties of the mandate of the Review Team.

The Review team will seek to gather information for 2012 – 2017 from these relevant sectors that will help address the issues of how leadership and governance were exercised during this period. This will be carried out through interviews with individuals identified by the team and scrutiny of the relevant documentation. Documentation may include, Minutes of Board, Senior Management Team, and Hospital Management meetings; as well as risk registers; operational and strategic plans; service improvement plans; and financial strategies. Other documentation may include incident reporting, complaints, and organisational structures (this list is not exhaustive). The team will meet families and carers to ascertain their observations of matters of leadership and governance.

The Review team will identify good practice in the HSC/NHS and the public sector that can provide benchmarks to evaluate how leadership and governance was exercised within the Belfast Trust. The team will always act fairly and transparently, and with courtesy.

Purpose of the Review

This review is being commissioned by the Health & Social Care Board & Public Health Agency (HSCB/PHA) at the request of the Department of Health. The purpose of this review is to critically examine the effectiveness of Belfast Health & Social Care Trust's leadership, management, and governance arrangements in relation to Muckamore Abbey Hospital for the five-year period preceding the adult safeguarding allegations that came to light in late August 2017.

The review should take cognizance of any relevant governance issues highlighted by other agencies such as RQIA and PSNI since 2017. Ultimately, the review seeks to establish if good leadership and governance arrangements were in place and failed and if so, how/why ; or were effective systems not in place.

Terms of Reference

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to quality, safety and user experience. Drawing upon families, carers, and staff's experience, conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

Strategic leadership

- Shared principles, values, and objectives across the Trust services for people with a learning disability
- The role of Belfast HSC Trust Board and Senior Management Team in providing leadership and oversight
- The role of Belfast HSC Trust Board and Senior Management Team in ensuring clarity of purpose for MAH

Operational Management

- Clarity of line-management arrangements
- Clarity of lines of accountability from ward staff through to Trust Board
- Clarity of roles and responsibilities of and between operational, governance, and professional leadership and management at the hospital
- Clarity of roles and responsibilities between staff in the hospital and community based clinical and key worker staff.
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour.
- Operational aspects of adult safeguarding arrangements.
- Operational systems for raising and addressing concerns about quality and safety of patient care.
- Operational aspects of service improvement arrangements.

Professional / Clinical leadership

- Professional adult safeguarding arrangements
- Clinical leadership within multidisciplinary teams
- Professional supervision (across all disciplines working in the hospital)
- Professional aspects of systems and supports for raising and addressing concerns about quality and safety of patient care (including those available to students from all disciplines on placement in the hospital).
- Continuous professional development arrangements for all levels of staff
- Process for introducing and monitoring the implementation of new evidence based professional practice and clinical updates
- Professional aspects of service improvement arrangements
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour

Governance

- Incident reporting and reviewing arrangements and how these informed patient care (to include restrictive practices)
- Clinical and practice audit
- Dealing with complaints
- Whistleblowing
- Inspection reports
- Health & Safety
- Risk assessment and management
- Arrangements for learning and improvement from the above.
- Monitoring and accountability arrangements for physical interventions
- Monitoring and accountability arrangements for seclusion.
- Multidisciplinary staff availability, working, and skill mix
- Delivery of evidence-based therapeutic interventions in line with NICE and other relevant clinical practice guidelines

Accountability

- Meaningful engagement with families of patients/carers
- Meaningful engagement with people who use the hospital's services
- Reporting and accountability arrangements
- Working arrangements with community-based services
- Openness to visitors and scrutiny

Hospital Culture and Informal Leadership

- Hospital culture across all staff in all professions/roles in all settings within the hospital.
- The extent of compassionate values based and human rights-focused practice in the hospital.
- The nature of the management approach to staff including the extent of formal and informal supports.
- Ward dynamics and relationships amongst staff teams including positions of power/influence in staff teams. This analysis should include any available information from the safeguarding investigation about the numbers, roles, grading, experience, training, length of service and shift patterns of staff alleged to have been directly involved in abuse and those alleged to have witnessed it but did not act on it.

Support to Families and Carers

- The DOH will engage PCC to provide independent support for families and carers who become involved in the review process.

Anticipated Outcome

Produce a set of recommendations for consideration and approval by the Muckamore Abbey Hospital Departmental Assurance Group in relation to the implementation of a governance and assurance framework for Muckamore Abbey Hospital & Belfast HSC

Trust; other HSC Trusts with Learning Disability Hospitals; and wider mental health and learning disability services.

Appendix 2

Curriculum Vitae of Independent Review Team Members

David Bingham

Before retirement from the NHS in March 2016 David was Chief Executive of the Business Services Organisation for Health and Social Care in Northern Ireland. He had spent most of his career in the public sector, with a background of General Management, Human Resources or Management and Organisational Development. In addition to his health service experience he had spent eight years in the senior civil service.

Maura Devlin

Maura is a registered nurse and currently the Northern Ireland council member of the Nursing and Midwifery Council. She was Director of Nursing and Midwifery Education in the Clinical Education Centre and previously worked in a range of assistant director roles in the health and social care sector in Northern Ireland. Since retiring, she has served as an independent chair for Fitness to Practice proceedings at the Northern Ireland Social Care Council. She currently works as a professional advisor to the Northern Ireland GP Federations.

Marion Reynolds MBE, BSc, Dip Soc Work, CQSW, Cert Adv Soc Work

Marion worked from 1975 to 2009 at practitioner, management, inspection, policy development, and commissioning levels in Family and Child Care services in Northern Ireland. She commissioned the full range of statutory family and child care services for the population of the Eastern Health and Social Services Board from 2006 to 2009. In addition she chaired the Board's Area Child Protection Committee. Previously she

worked as a Social Services Inspector, at the DHSSPS (1992 to 2005). Marion contributed to the development of professional standards for children's services.

Since 2010 Marion has worked as an Independent Social Worker providing independent social work analysis and reports for a range of social services providers in both Northern Ireland and the Republic of Ireland.

Marion is currently involved as a: member of the Exceptional Circumstances Body of the Department of Education (2010 to present), member of the Northern Ireland Advisory Group of Homestart (UK) (2005 to present); Board Member Alpha Housing Association (2012 to present). Previously she was a Commissioner with the Northern Ireland Human Rights Commission (2009 to September 2017).

Katrina McMahon

Katrina is a former acting Head and Business Manager of the HSC Leadership Centre. She worked in the Health and Social Care sector for 37 years in various management roles within HSC Trusts and the Management Development Unit. Her particular areas of interest are in business systems and managing complex health care based projects.

Appendix 3

List of documentation received by the Review Team

File Number	**Origin**	**Date Received**	**Comment**
1	Belfast Trust	21/2/20	Policies and Procedures
2	Belfast Trust	21/2/20	Policies and Procedures
3	Belfast Trust	4/3/20	Policies procedures and reports
4	Belfast Trust	6/3/20	SAIs' and Incident reports
5 (File 1)	Belfast Trust	6/3/20	CORE minutes Modernisation Minutes
6 (File 2)	Belfast Trust	6/3/20	Professional Senior Nurse Minutes
7 (File 3)	Belfast Trust	6/3/20	Nurse Management Structure Re-settlement Information Audit Lead Minutes Governance Minutes
8 (File 4)	Belfast Trust	6/3/20	Learning & Children's Senior Managers Minutes
9	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits

10	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits
11	Belfast Trust	1/6/20	Assurance Standards Trust Board Updates + MAH Senior meetings
12	Belfast Trust	1/6/20	Ennis Investigation
13	Belfast Trust	1/6/20	Information relating to Ennis Report
14	Review Team		CCTV file
15	Belfast Trust	8/6/20	Nurse Training Plan Nurse Governance Structures KPIs' Nurse Governance Quality Reports
16	Belfast Trust	8/6/20	Nurse Management Plans Nursing & Midwifery Workforce Steering Group Assurance Framework
17	Belfast Trust	16/6/20	Trust Board Sessions, Exec Team minutes Statutory Function Reports Risk Registers
18	Belfast Trust	16/6/20	Quality improvement/Quality & Safety

			Improvement Plans
19	Belfast Trust	16/6/20	Adult Protection Policy Adult Safeguarding Policy Nursing KPIs'
20	Belfast Trust	26/6/20	Risk Registers Records of Leadership Walkrounds Nursing Governance Nursing Workforce Minutes
21	Belfast Trust	26/6/20	Minutes of Social & Primary Care Directorate Team meetings LD Senior Management Team Meetings

File Number	**Origin**	**Date Received**	**Comment**
22	RQIA	7/2/20	Documents A-G
23	DOH	28/2/20	Ennis documentation Early alerts received by DoH re Muckamore Whistleblowing Complaints Adult Safeguarding Restraint & Seclusion Statistics on Workforce Assaults

24	HSCB/PHA		Early Alert Position Report – Brown Complaint
25	Review Team		Ennis Investigation
26	Review Team		Additional ad-hoc documents
27	Belfast Trust		Documents from Chief Executives office
28	Departmental Professional Nursing Officer		Best Practice Documentation

Appendix 4

Meetings held with key personnel

Date	Job title
4/2/20	Chief Executive, Regulation &Quality Improvement Authority
13/2/20	Chief Executive, Belfast HSC Trust
18/2/20	Director of Primary Care, DoH
18/2/20	Social Services Officer, DOH
18/2/20	Nurse and Specialist Learning Diasability Manager, seconded to MAH
20/2/20	Officials , DoH
20/2/20	Social Services Officer, DOH
21/2/20	Director of Neurosciences, Radiology and MAH
21/2/20	Permanent Secretary, DoH
25/2/20	Programme Manager, Mental Health & Learning Disability, PHA
27/2/20	Medical Director and Director of Improvement Regulation & Quality Improvement Authority
27/2/20	Director of Nursing & Allied Health Professions – PHA
27/2/20	Social Care Lead Mental Health & Learning Disability, PHA
2/3/20	Manager Independent Advocacy Service,Bryson House
2/3/20	Health Minister
3/3/20	Chief Nursing Officer, DoH
5/3/20	Complaint Support Manager, PCC

5/3/20	Director, Mencap
6/3/20	Former Director of Adult, Social and Primary Care
13/3/20	Director of Social Work/Children's Community Services
16/3/20	Deputy Director and DRO, HSCB
21/5/20	MP
21/5/20	Chair of Parents & Friends of Muckamore Abbey Hospital
22/5/20	Director, Northern HSC Trust
26/5/20	Parent and Aunt
28/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
28/5/20	Hospital Service Manager/Assoc Director of Learning Disability Nursing, MAH
29/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
2/6/20	Hospital Service Manager/ Assoc Director of Learning Disability Nursing, MAH
4/6/20	Executive Director of Nursing and User Experience
4/6/20	Parent
5/6/20	Senior Manager for Service Improvement and Governance, Belfast HSC Trust
12/6/20	Ennis Investigation Officer
15/6/20	Former Director of Adult Social & Primary Care
18/6/20	Chief Executive, Belfast HSC Trust
20/6/20	Chairman, Belfast HSC Trust
22/6/20	PSNI
23/6/20	Non-Executive Director, Belfast HSC Trust

23/6/20	Nursing Lead for Transformation, DoH
23/6/20	Clinical and Therapeutic Services Manager, MAH
25/6/20	Trust Adult Safeguarding Specialist
25/6/20	Social Services Officer, DOH
25/6/20	Executive Director of Nursing and User Experience, Belfast HSC Trust
30/6/20	Former Director of Social Work, RQIA
3//7/20	Former Director of Social Work, Family and Childcare
16/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Clinical Lead, former Clinical Director

Appendix 5

TIMELINE OF RELEVANT INCIDENTS: MUCKAMORE ABBEY HOSPITAL 2012 - 2020

November 2012 – Complaints made of physical and emotional abuse of patients in Ennis Ward. PSNI informed. Review took place under the Trust's Safeguarding Vulnerable Adults Policy.

October 2013 - Date of Ennis Safeguarding Vulnerable Adults Report.

August 2017 - Complaint by a parent of a non-verbal male patient that his son was being abused at the Intensive Care ward at Muckamore Abbey.

August 2017 - Information that video recording may be available in relation to the allegations of patients being ill-treated by hospital staff. PSNI and the Trust began investigating the allegations and reviewing the video recordings.

November 2017 - Four staff members had been suspended and the BBC reported that the allegations "centred on the care of at least two patients".

January 2018 - The Trust established an Independent Expert Group to examine safeguarding at the hospital between 2012 and 2017. The report's authors included Dr Margaret Flynn, who oversaw the review into the 2012 Winterbourne View hospital scandal in England which saw six care workers jailed.

July 2018 - The Irish News reported details of CCTV footage allegedly showing ill treatment of patients. The Trust apologised "unreservedly" to patients and their families. It further stated: "As part of the ongoing investigation and a review of archived CCTV footage, a further

number of past incidents have been brought to our attention. It confirmed that a further nine members of staff had been suspended at MAH.

August 2018 - The BBC reported that between 2014 and 2017, five vulnerable patients were assaulted by staff at Muckamore Abbey Hospital. In response to a Freedom of Information (FoI) request the Trust confirmed that in hospital between 2014 and 2017 there had been more than 50 reported assaults on patients by staff, with five investigated and substantiated.

November 2018 - The Independent Expert Group established by the Trust to enquire into the allegations of August 2017 completed its report, *A Way to Go*

December 2018 - The *A Way to Go* Report which enquired into allegations of abuse and neglect at Muckamore Abbey was leaked to the media. By this stage, 13 members of the nursing staff were suspended and two senior nursing managers were on long-term sick leave.

December 2018 - A mother of a severely disabled Muckamore patient gave her first broadcast interview to BBC News NI. She described the seclusion room her son was placed in as "a dark dungeon". CCTV footage from the Psychiatric Intensive Care Unit (PICU) showed her son being punched in the stomach by a nurse. The footage, taken over a three-month period, also showed patients being pulled, hit, punched, flicked and verbally abused by nursing staff. The Belfast Trust confirmed that the seclusion room use was being reviewed though it was still used in emergencies.

January 2019 - The chair of Northern Ireland's biggest review into mental health services, Prof Roy McClelland, told BBC News NI that the allegations emerging from Muckamore could be "the tip of the iceberg."

February 2019 - The Chief Executive of the Belfast Health Trust, Martin Dillon, tells the BBC "the buck rests with me" in his first interview on the Muckamore abuse allegations. "Some of the care failings in Muckamore are a source of shame, but my primary focus is on putting things right," he said.

August 2019 - The police officer leading the investigation said that CCTV footage revealed 1,500 crimes on one ward alone. The incidents happened in the psychiatric intensive care unit over the course of six months in 2017-18. The police revealed the existence of more than 300,000 hours of video footage.

August 2019 - Northern Ireland's health regulator, RQIA, took action against the Belfast Trust over standards of care at Muckamore. Three enforcement notices were issued by the Regulation and Quality Improvement Authority (RQIA) over staffing and nurse provision, adult safeguarding, and patient finances. In a statement to the BBC, the Trust said it was trying to develop a model of care "receptive to the changing needs of patients".

September 2019 - Northern Ireland Secretary, Julian Smith, apologises for the pain caused to families by the situation at Muckamore Abbey Hospital, during a meeting with the father of one of the patients.

October 2019 - Dr Margaret Flynn, co-author of the *A Way to Go* Report into safeguarding at Muckamore tells BBC News NI that the hospital "needs to close". Her November 2018 report found that patients' lives had been compromised. She revealed that some patients had been manhandled and slapped on some occasions. She said that she was disappointed that the facility was still open.

October 2019 - Police investigating abuse allegations make their first arrest in the Muckamore investigation. A 30-year-old man was arrested by officers in Antrim on 14th October but he was later released on police bail.

October 2019 - Belfast Health Trust reported that it has spent £4m on agency staff in order to cover vacancies at Muckamore, because so many members of staff have been suspended during the abuse probe. The current tally of suspensions on 18th October 2019 stands at 36. Agency nurses are being drafted in from England and further afield to care for patients. It is reported that they are being paid up to £40 an hour.

November 2019 - A 33-year-old man becomes the second person to be arrested in the Muckamore abuse investigation. He was detained in Antrim on 11th November but was later released on police bail.

December 2019 - Police make more arrests in the Muckamore abuse investigation. A 33-year-old man was arrested in the Antrim area on the morning of 2nd December. The following day, officers said the man had been released on bail pending further inquiries. In the same week, the Irish News reports four more suspensions, bringing the total number of Muckamore staff suspended by health authorities to 40. The Belfast Health Trust confirms that all 40 employees have been "placed on precautionary suspension while investigations continue". On 16th December, a 36-year-old woman became the fourth person to be arrested and questioned about ill-treatment of patients. She was released on police bail the following day.

December 2019 - BBC News NI reveals that 39 patients who should have been discharged will have to stay at Muckamore Abbey Hospital because there are no suitable places for them in the community. The same day, RQIA announces the results of a three-day unannounced inspection of Muckamore, including an overnight visit. The RQIA inspection finds there have been "significant improvements" but it

still has concerns about financial governance and safeguarding arrangements.

January 2020 - Muckamore patients' families meet the new Health Minister, Robin Swann, following the restoration of Northern Ireland's devolved government. A spokesman for the campaign group Action for Muckamore, says that he was disappointed that Mr Swann could not give them assurances that a full public inquiry would take place. The meeting followed a fifth arrest in the abuse investigation. A 34-year-old man was questioned before being released on police bail the following day, pending further inquiries.

January 2020 - Terms of Reference for a review of leadership and governance at Muckamore Abbey Hospital and at Belfast Trust were agreed by the HSCB and PHA which had been requested by the DoH to conduct such a review.

January 2020 - Man arrested as part of MAH investigation. The 5th arrest.

February 2020 - Male nurse who was suspended was arrested by the police; the 6th arrest.

February 2020 - Muckamore Abbey Hospital Review Team commence the review into leadership and governance.

March 2020 - A 28 year-old woman who was arrested in the police investigation of patient abuse at Muckamore Abbey, in Co Antrim has been released. This was the 7th arrest.

March 2020 - MAH Review Team temporarily stood down due to the Coronavirus Pandemic. Timescale for delivery of interim findings and final reports necessarily amended.

April 2020 - The Public Prosecution Service writes to families for the first time confirming that it has received an initial file from the PSNI in respect of seven staff members which it is now reviewing.

Appendix 6

Overview of Ennis Report Appendix 1 of that Report

Source	Incident Number(s) (inclusive)	Comments
[redacted]	1 – 15	**1, 3, 5, 7, 8** relate to staff alleged inappropriate or rough handling of 3 patients ([redacted], [redacted] & [redacted]). Others appear practice issues
[redacted]	16 – 18, 52 - 53	Incident **16** relates to rough handling of [redacted]. Practice issues: incident **17** similar to incident **50**; incident **18** similar to **37**, **51** and **59**. **Part of 52** may be the same incident as **49** expanded. **53** may be incident **17**.
[redacted]	19 – 23, 59 - 63	**59 – 63** are repeats of **22, 20, 19 & 44** one is similar to **37**
[redacted]	24 – 25	Describes 2 incidents relating to [redacted] unclear what the allegations are
[redacted]	26, 45 - 48	**26** rough handling of [redacted] when redressing her. Not repeated in [redacted] statement to HR in 2014. **45 – 48** comments in respect of [redacted] stripping and belt issues. Should cross-reference with [redacted] HR statement in May 2014
[redacted]	27 – 28	In the statement to HR [redacted] stated incident **27** was not a concern and it was an Erne member of staff, not Ennis, who provided an explanation. In relation to **28** said staff knew patients well & '*I could not praise the staff enough for the work they do.'*
[redacted]	29 – 31, 54 - 58	**29** in the interview with HR this comment was refuted: 'denied that staff had taken [redacted] hand out of [redacted]' **30 – 31** practice issues.
[redacted]	32 – 39	32 rough handling (? Of [redacted]) Incident **34** similar to that described at **24**, form of restrictive practice as described. Incident **35** practice issue. Incident **36** similar to incident **48.** Incident **37** similar to **59.** Incident **38** practice issue.
Patient's	40	Rough handling allegation

brother		
Multiple Private Provider staff	41 – 44	Incidents relate to lack of induction, lack of engagement with patients, lack of adequate staffing, culture on the ward. Should cross-reference with [redacted], [redacted] and [redacted] statements to HR in May 2014
[redacted]	49 – 51	Incident **49** repeat of **59** and other allegations in relation to rough handling of [redacted] and fitting belt too tightly. In statement to HR states witnessed this on one occasion only. Following practice issues: incident **50** repeat of **17**; incident **51** similar to incidents **18**, **37** and **59**.

Appendix 7

Strategy Discussions/Case Conferences and Case Records– Information Base for Review Team's Analysis in respect of Ennis

Strategy Discussions/Case Conferences

1. In keeping with the Trust's adult safeguarding policy, the investigation was conducted on a multidisciplinary basis and jointly with the PSNI given the criminal nature of a number of the allegations. Strategy meetings and case conferences were convened under the Joint Protocol for Investigation 2009 arrangements and the Regional Adult Protection Policy & Procedural guidance (Safeguarding Vulnerable Adults) 2006 on the following dates:

   - 9th November 2012 Vulnerable Adult Strategy discussion;
   - 15th November 2012 second Vulnerable Strategy Meeting;
   - 12th December 2012 strategy discussion;
   - 20th December 2012 strategy discussion;
   - 9th January 2013 strategy discussion;
   - 29th March 2013 strategy discussion;
   - a meeting scheduled for the 14th May 2013 was cancelled as the investigation was not completed;
   - 5th July 2013 Adult Safeguarding Case Conference;
   - 28th October 2013 Adult Safeguarding Case Conference.

2. The Safeguarding Vulnerable Adult policy requires that where there is confirmed or substantial risk of abuse a case discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify

risks and the actions necessary to manage those risks.[104] The purpose of the case discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan.[105] Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the Core Group who will work together to implement and review the Care and Protection Plan.[106]

3. The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.[107] The Care and Protection Plan will identify the person who is responsible for monitoring its operation. It should be reviewed within 10 working days of its implementation and should be reviewed at a 3 monthly interval at minimum.[108]

4. The initial meeting was held within the required timeframe and comprehensively considered the allegations received by the Trust on the 8th November 2012. No patient or family member was invited to attend the meeting; no explanation was provided although from the discussion it was apparent this was in the patients' best interests. A Protection Plan was agreed, each task was not assigned to a named attendee.

5. At the second discussion convened on the 15th November 2012 MAH staff were excluded to 'facilitate a more independent investigation.' The meeting agreed that the Designated Officer would be the main link to hospital staff. The meeting noted that there were 'some further concerns about possible physical abuse had emerged, also poor care practice and a general concern about an uncaring

[104] Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance, 2006, Para. 14.10, Page 36
[105] Ibid par. 15.1, Page 38
[106] ibid par. 15.7, Page 40
[107] ibid par. 15.13, Page 42
[108] ibid par. 16.3 – 16.4, Page 43

culture in the ward.' The meeting considered the complaints made against individual staff and reached conclusions about whether or not a staff member could be reinstated or placed on precautionary suspension. Much of the discussion at this meeting surrounded perspectives on professional practice at Ennis. The meeting did not commence with feedback on how aspects of the Protection Plan had operated since the initial strategy discussion. A revised Protection Plan was agreed the staffing component of this was to be addressed by the Designated Officer with senior Trust managers. The Review Team considered that preliminary discussion with MAH managers and delegating the staffing issue to them to pursue with senior managers would have been a more inclusive working arrangement.

6. The third strategy meeting convened on the 12th December 2012 highlighted information still awaited from MAH medical staff. An update on progress with interviews was provided. As of that date the PSNI had not interviewed any staff employed by the Private Provider. The meeting was informed that a Co-Director of Nursing (Education and Learning) had been identified to lead and co-ordinate monitoring arrangements at Ennis. The Designated Officer confirmed that after checking she was now in a position to confirm that since the last meeting monitoring staff 'were in place 24 hours a day and that they were supernumerary.' There was considerable discussion about staffing levels at Ennis. It was noted that 2 of the 5 patients named might be able to provide some information at interview. The agreed Protection Plan remained 24 hour monitoring with the precautionary suspension of 3 staff members continuing The Review Team considered that greater focus was required on the alleged incidents in an effort to bring the safeguarding investigation to an early conclusion.

7. The fourth strategy meeting convened on the 20th December 2012 had in attendance a member of the Trust's HR Department and the Co-Director of

Nursing (Education and Learning). The MAH Service Manager also attended this meeting. During this meeting the police representative noted that it would only interview patients or staff in respect of criminal allegations not professional practice matters. The police confirmed that the Private Provider's staff have now all been interviewed and statements taken. The police noted that these staff had not raised similar concerns about other wards on which they had worked. The Designated Officer noted that this was positive she remarked that 'there were clear differences being reported between it [Ennis] and other wards.

8. Three staff were identified by the Private Provider's staff whose identify could not be confirmed as their names were unknown. There was a discussion about whether a patient being held constituted a safeguarding concern. In this respect the police confirmed that this matter would not be investigated as a criminal matter. It was decided that 'social services would continue to interview them in relation to the allegations.' The police asked the Trust not to proceed with disciplinary measures before the police interviews. HR asked for a police timescale as it was important for the Trust to move ahead with its processes, It was agreed that HR interviews would be completed independently of safeguarding interviews. Fourteen action points were agreed at the end of this meeting the majority of which were assigned to named members of the strategy team.

9. This meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run in parallel. It also highlighted that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considers it essential that at the outset each allegation is assessed on the basis of the existing information and categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

10. The fifth strategy meeting was held on the 9th January 2013. Both of the Designated Officer's line managers attended this meeting [a Co-Director for Learning Disability Services and a Service Manager for Community Learning Disability Services]. The Co-Director raised his concern about the list of allegations presented by the Designated Officer some of which were specific while others were negative comments. He stressed the need to obtain evidence and facts, which was difficult in relation to negative comments. The Review Team considers that had the initial allegation been disaggregated (see Para 8.29) that the safeguarding investigation would have been able to focus its energies on abusive issues. The RQIA representative sought clarity on MAH staff now attending the Co-Director stated that the Trust's senior management had 'concluded that it was important she was in attendance to clarify any issues specific to nursing practice on the wards in MAH…'

11. This meeting commenced with a consideration of progress against the actions established at the previous meeting. The Review Team considers such an approach commendable as it serves to focus attention on any matters which remain outstanding. Concerns raised by a patient's sister during contact were discussed and it was agreed to recommend that these be progressed through the Trust's complaints procedures. This meeting agreed an alteration to the 24/7 monitoring arrangement such that it could now be undertaken by newly appointed staff at Ennis at Band 5 and above. Fifteen action points were agreed. Each was assigned to a named individual; such practice is commendable. The next meeting was scheduled to be held on the 1st February 2013.

12. The next meeting was held on the 29th March 2013 nearly two months later than initially scheduled. Neither the Co-Director of Nursing nor the MAH staff member was in attendance. Consideration had been given to deferring the meeting due to their non-availability but as the police wished to provide feedback it had been decided to proceed. The focus was therefore an update from the PSNI and on

further investigation planning. The Co-Director observed that 'while recognizing that the investigation is incomplete, he emphasised that we are 5/6 months into this investigation and there is no evidence of institutional abuse.' He further noted that neither the Co-Director of Nursing nor the MAH staff member feel there is indication of institutional abuse at this stage. These are the first references to institutional abuse in the records of these meetings. All staff in the Ennis ward are to be interviewed by two community based learning disability social workers using an 'agreed script with a semi structured interview questionnaire.' The meeting also considered progress against the actions agreed at the previous meeting. At this stage neither patients nor all staff working at Ennis had been interviewed by Trust staff; more than five months after the receipt of the allegations. The Review Team considers this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

13. The penultimate meeting was held on the 5th July 2013 at which copies of the draft final report was circulated. The Public Prosecution Service had still to assign a public prosecutor to the case. The Co-Director, Learning and Disability Services, asked that pressure is kept on the process as public money is being spent with staff members remaining on suspension. He asked if the disciplinary process could commence pending an outcome of the police investigations. He asked that a meeting take place with the Trust's HR Department to discuss proceeding with disciplinary proceedings. As the draft report had been circulated at the commencement of the meeting there was not time to consider it, although the DO 'advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the report. It was agreed to defer until after the meeting as there had not been enough time to go through the report prior to it. One of the patient interviews remains outstanding as there is no Speech and Language therapist during July.

14. The Co- Director, Learning and Disability Services, noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with Private Provider staff. He asked for the outcome of the investigation in relation to these matters as 'the report refers at various points to 'no conclusion drawn'.' The DO replied that no evidence had been found to substantiate the allegations but 'the investigating team felt the [Private Provider staff] were credible.' The DO agreed to make a distinction between Ennis prior to the allegations and after the Improvement Plan.

15. There was a discussion about whether there was evidence of a culture of bad practice. The DO replied 'that the conclusions reached by the investigation team was there was enough to warrant considerable level of suspicion … although [the Private Provider staff] also identified good practice which would suggest that any poor practice was not totally widespread.' The meeting concluded by a review of the protection plan and agreeing a series of changes.

16. The final case conference meeting [for which minutes are available on case records] was held on the 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation in Ennis ward. The purpose of the meeting was to:

- discuss the conclusions and recommendations following the safeguarding investigation;
- discussion of updates to families/relatives of service users named in the report; and
- an update on the police investigation.

The DO noted that amendments had been made to the draft report tabled at the previous meeting and had been emailed to participants. No feedback/issues were received in respect of the amended report.

17. The PSNI advised that it could be several months before the charges against the two staff came to trial. It was recommended by investigation team that the disciplinary action commence. MAH Service Manager confirmed that this action had commenced but was at an early stage. The Co-Director Learning Disability Services recommended advice be sought from Human Resources 'before staff were spoken to'.

18. The DO noted the difficulty the investigation team experienced in weighing the 'very different evidence provided by the two staff teams [MAH and Private Provider staff]. It was not possible to identify all the staff allegedly involved in poor practice. There was not enough evidence to warrant disciplinary action against some staff due to lack of corroboration and their own differing accounts. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the Private Provider's staff's report as evidence. Uncorroborated reports being viewed as evidence was discussed. 'There was considerable discussion in relation to having sufficient evidence to support the allegations made.' It was also noted that there were discrepancies in the reports received from the Private Provider's staff in relation to induction.

19. The staffing situation at Ennis prior to the events of November 2012 was discussed as was the arrangements now in place to 'check daily staffing numbers on a daily basis throughout the hospital.' Hospital management also accepted the recommendation that 'the hospital needs to review for any practice on Ennis ward that could be deemed restrictive.' A successful bid has been made for psychology support in resettlement wards to help with meeting patients' needs. Other professional services had also commenced in Ennis Ward.

20. The impact of the investigation on Ennis staff was recognised and consideration was afforded to meeting their need for information about the investigation and its

outcome. The PSNI noted that in respect of the charges it was pursuing this could not be shared with staff but more general feedback was possible. The Co-Director, Learning and Disability Services noted that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' RQIA supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked 'to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

21. A further meeting was arranged for the 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

Case Records

22. There is evidence on the files examined that the MAH Service Manager was at times reporting to the Operations Manager and safeguarding lead. An example was in as email of the 16th November 2012 when confirmation was provided that a number of actions had been taken in line with the findings at the Strategy Meeting held on the 15th November regarding the absence of supporting evidence in respect of a student nurse and a member of staff which would enable her return to duties. The Operations Manager was asked to 'confirm the following: 'the band 6 or above is required to be supernumerary; the monitor will be on shift 24 hours per day; that they will have no substantive role in Ennis in the past 3 months, 6 months, or year can you give a time frame; will the independent monitors be in place for the 24 hour period when you make the arrangements.'

23. The Review Team had some concern that the safeguarding investigation was extending its role into managing the situation at Ennis. The purpose of a case conference is to evaluate the available evidence and to determine an outcome based on balance of probability. In complex situations a strategy discussion is convened which comprises key people who meet to decide the process to be followed after considering the initial available facts. These meetings may conclude by making recommendations to the constituent agencies involved in a specific case. The membership of these meetings is independent of the management in each of the constituent organisations. Accountability rests with individual agencies for progressing recommendations. Failure to comply with recommendations can be brought by the safeguarding lead to the attention of individual agencies for it to take remedial action, where required.

24. The Review Team noted on the 5th March 2013 that the Operation Manager emailed her line managers and the MAH Service Manager noting that while 'many of the reports [monitoring reports] continue to be very positive' she wished to meet to discuss 'the greater number of quality concerns reported' since the withdrawal of supernumerary monitors. On the 6th March the MAH Service Manager's responded stating: 'in continuing to review the monitoring forms I feel the concerns noted are similar in nature to the previous monitors, I am reassured by the open and transparent reporting the monitors are providing… A weekly support meeting is in place to discuss concerns. We have a number of action plans in place to address [a range of identified issues].'

25. The Operation Manager's response of the same date while noting her continued preference for a meeting asked as an alternative for copies of the action plans and for details in respect of the weekly support meetings. She also noted that from the monitoring reports she could not identify whether or not staffing levels are appropriate. It is the opinion of the Review Team that the role of the DO in this respect was not appropriate. It carried the potential to undermine the

managerial system at MAH. In the view of the Review Team reporting on compliance with recommendations was the proper way to seek to monitor compliance levels. In situations where there concerns were identified the appropriate response would have been to seek further assurances either from the MAH Service Manager or the Director of Nursing or her nominee rather than assuming what appears to have been a quasi-oversight function. There was also evidence on file of the Operations Manager being kept informed of therapeutic input in respect of individual patients.

26. The Review Team also found in the community services Ennis files a series of emails about matters such as ward keys for Ennis which did not appear germane to the safeguarding investigation. The chain of emails was copied to the Operations Manager to inform her that 'keys for Ennis have now requisitioned and arrived'. Confirmation of capital funding approval was also provided along with a detailed internal inspection schedule of the ward. The degree of apparent oversight of the Ennis ward was higher than the Review Team would have expected. The safeguarding investigation took from the 8th November 2012 until the 23rd October 2013 which is longer than one would have expected, especially given the nature of the complaints. Given the significant amount of work carried by the DO the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation.

27. The Trust arranged for its Co-Director of Nursing (Education and Learning) to engage with managers at MAH in relation to safeguarding patients in Ennis. This staff member was independent of MAH. She undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;

- consideration of progress against draft improvement plans; and
- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

A comprehensive report was produced at the conclusion of the second visit made on the 9th January 2013 which is available on the safeguarding files. This staff member was also a member of the multidisciplinary safeguarding team. As the Service Manager from MAH was not, for a period, a member of that team this staff member acted as a communications link between the safeguarding team and MAH thereby ensuring that matters identified were communicated and taken forward within both processes.

Appendix 8

Timeline in respect of Mr. B's Complaint

Date	**Information**
12.08.17	Member of staff (healthcare support worker) assaulted Mr. B's son (AB) a patient in PICU. The incident was witnessed by a staff nurse who reported it to the Nurse in Charge. Neither of the staff completed an Adult Safeguarding Form (ASP1). The Nurse in Charge emailed the Deputy Charge Nurse (DCN) with a request to meet to discuss 'a concern'. This meeting occurred on 17th August. The DCN considered the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN emailed the staff nurse for more details. The incident was not escalated at that time.
20.08.17	The DCN received an allegation that another patient on PICU had allegedly been verbally abused by the healthcare support worker involved in the AB incident. The DCN emailed the Charge Nurse (CN) for advice. The CN was not on duty that day.
21.08.17	The CN returned of annual leave for a late shift. The CN immediately escalated the concerns to Senior Management and requested ASP1 forms be completed on the ward. The CN reminded staff of their responsibilities under adult safeguarding arrangements. The Acting Head of Service was contacted and action discussed. The precautionary suspension of the staff member was agreed. The Adult Safeguarding Officer was notified and an interim protection plan was put in place. The PSNI and the Community Designated Officer as well as patients' next-of-kin were notified about events in respect of the incidents. A single-agency, PSNI led investigation was confirmed. The police officer stated that interviews would be scheduled following his return from annual leave 11th September 2017.
22.08.17	At 7.30 am the healthcare support worker at the start of his shift was

	placed on precautionary suspension by the Service Manager and the Senior Nurse Manager. Associate Director of Social Work, as safeguarding lead, was notified of the incident by the Service Manager.
25.08.17	On the way to a scheduled meeting at MAH to discuss the assault on his son, Mr. B contacted RQIA about the situation. RQIA contacted the Senior Nurse Manager for confirmation that the safeguarding processes had commenced. Mr. B met with the Senior Nurse Manager and the adult safeguarding officer. The timing of the meeting was to facilitate Mr. B securing support from a Carer Advocate. Mr. B was provided with details of the Community Designated Officer in case he requires any further information. Mr. B at this meeting asked if there was CCTV footage of the incident. He was told that CCTV was not operational. He did not accept this response. Mr. B made a formal complaint in respect of events concerning his son. He was telephoned on 29th August 'to confirm we have now received the email he tried to send on 25th August' (email sent to wrong address). The Senior Nurse Manager and the Service Manager held a conference call with the PSNI to clarify an approach to investigation. The police-allocated case officer gave permission for the safeguarding officer to speak to the witness of the alleged incident of 12th August 2017 on that staff member's return from annual leave on 29th August 2017.
28.08.17	Mr. B met with his MP about his concerns about the treatment of his son. The MP immediately contacted the Chief Social Services Officer at the Department.
29.08.17	Mr. B emailed seeking a response to his complaint of 25th August 2017. It sent this email to the HSC Board. Within a half an hour of receipt of this

	email, an email was sent to the Belfast Trust stating that the HSC Board had called asking had it received the complaint and asking that someone contact Mr. B by phone. His mobile number was provided.
29.08.17	Mr. B's complaint of 25th August 2017 was received by the Trust as there had been an error in the email addressed used on 25.08.17. The safeguarding lead spoke to the witness who confirmed that he had seen a shove or possibly a hit to stomach area of Mr. B's son. This was not a formal interview as instructed by the police due to the ongoing PSNI investigation. Incident of alleged verbal abuse of a patient by a healthcare worker was being managed by the designated community social worker.
29.08.17	The Directorate of Legal Services (DLS) was contacted for a legal view on accessing CCTV footage. This was subsequently followed up in writing, possibly on 4th September 2017. At some point the possibility that the incident of 12th August had been captured on CCTV was discussed by senior managers at MAH. The Review Team has not been able to identify when this possibility was initially raised, nor when the footage was first checked. It would appear however, that by 29th August 2017 there was awareness that there was CCTV footage available and the question arose of what, if any, use could be made of it. There was a belief among the staff interviewed by the Review Team that the CCTV would become operational on 11th September 2017.
29.08.17	Trust Complaint Department representative forwarded Mr. B's complaint to the Co-Director of Learning and Disability Services, noting that the Governance Lead had already advised that it would be 'investigated under safeguarding in the first instance … When the safeguarding investigation is complete, we will respond to the complaint.'

29.08.17	The Co-Director of Learning and Disability Services emailed the Governance Lead at MAH in respect of Mr. B's complaint stating: 'Not a complaint. Being investigated under safeguarding by PSNI.' The Co-Director of Learning and Disability Services also emailed the Trust's Complaints Department in response to an email from it noting that 'when the safeguarding investigation is complete we will respond to the complaint'. The Co-Director of Learning and Disability Services stated in her response: 'Complaints need to write and tell [Mr. B] it is being investigated under safeguarding.
30.08.17	The Governance Lead at MAH emailed the Trust's Complaints Department stating: 'this is being investigated under safeguarding so is not a complaint.' In keeping with the email advice she had received from the Co-Director of Learning and Disability Services.
30.08.17	The Trust's Complaints Manager replied to Mr. B acknowledging receipt of his complaint. She advised that once the safeguarding investigation had completed that 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009)'. The letter also advised Mr. B that 'a member of the Adult Safeguarding team will be in contact with you shortly.' This letter was shared in draft with MAH Governance Lead and approved by same.
30.08.17	RQIA contacted the Trust's Director of Social Work seeking assurance about safeguarding training for staff.
30.08.17	Mr. B's MP met with the Departmental Director of Mental Health, Disability and Older People to discuss Mr. B's concerns about his son's care.
31.08.17	The Trust's Complaint's Department emailed the Co-Director of Learning and Disability Services advising that, 'complaints have written out to Mr. B [on 30th August 2017] and closed down as a complaint.' The letter to Mr. B stated however, that the complaint had been set aside pending the completion of a safeguarding review.

31.08.17	A representative of the Department and the HSC Board emailed the Co-Director of Learning and Disability Services following contact from Mr. B.
01.09.17	The Service Manager prepared an SAI form in respect of the incident regarding Mr. B's son. This was returned to her by MAH's Governance Department stating that it did not meet the criteria for an SAI.
06.09.17	The DLS responded stating that as the matter was of a safeguarding nature, the Trust was at liberty to access the CCTV footage.
07.09.17	Request to Service Manager from the Co-Director of Learning and Disability Services for an Early Alert following contact with the Department. There is no reference to CCTV footage in the Early Alert. Director of Nursing and CNO advised by Service Manager of the Early Alert by the Service Manager.
08.09.17	Director of Mental Health, Disability, and Older People at Department provided Mr. B's MP with preliminary information provided by the Trust.
17.09.17	Service Manager contacted the investigating officer upon his return from annual leave. She advised him of the possibility of CCTV footage.
18.09.17	Information on staff roster forwarded to PSNI as requested.
19.09.17	Service and Improvement Manager viewed CCTV footage to check if the incident of 12th August 2017 was available.
20.09.17	Service Manager and Service and Improvement Manager viewed the footage. The matter was then escalated to the Directors of Nursing, Social Work, and Medicine. This is the first evidence of information being brought to the attention of the Executive Team and Trust Board members. Hand written notes taken by the Director of Medicine confirm the date as 20th September 2017.
20.09.17	Departmental Director of Mental Health, Disability, and Older People provided Mr. B's MP with an update based on the Trust's Early Alert and advice from Belfast Trust
21.09.17	CCTV download completed. Viewing arranged to identify patients/staff.

	Present at the viewing were the: Clinical Director, Service and Improvement Manager, Senior Nurse Manager, the Ward Consultant, the safeguarding officer and the Assistant Medical Director.
22.09.17	Meeting held to discuss concerns and their management. Chaired by the Director of Adult, Social and Primary Care, attended by Service Manager, the Co-Director Mental Health Services, and the Assistant Service Manager, Learning Disability
24.09.17	The Co-Director Mental Health Services made an unannounced visit to PICU.
25.09.17	The RQIA lead inspector for MAH updated by the Service Manager and the Clinical Director.

Belfast Trust has today welcomed the publication of '**A Review of Leadership and Governance at Muckamore Abbey Hospital**'.

Chief Executive, Dr Cathy Jack said, 'On behalf of the Belfast Trust I welcome the publication of this Review and I apologise unreservedly to those patients and their families who have been failed by this Trust. It is clear there were serious failings in leadership and ineffective escalation of serious matters at Muckamore despite appropriate governance structures. This contributed to an environment which enabled the serious maltreatment of vulnerable people to go unnoticed for so long. This is a matter of profound regret and for that I am deeply sorry.'

Dr Jack continued, 'I unreservedly apologise to those patients who suffered as a consequence of these failings and to their families who had every right to expect their loved ones were being cared for safely and with respect, dignity, and compassion.'

This Review is part of a series of reviews initiated over the last few years to begin to better understand how such a culture and an environment could have existed and to ensure it can never again be perpetuated.

We acknowledge this is a very painful and lengthy process for patients, families, and carers, past and present. But we are committed to ensuring that the outcomes will lead to better and safer care.

Since the maltreatment of patients has come to light significant lessons have already been learned and many improvements have been put in place to protect against this happening again. We now have rigorous processes to ensure the safe care of patients and we actively encourage a culture of greater openness amongst our staff and our families.

Additionally, there have been many significant improvements that are now embedded and we are confident that Muckamore Abbey Hospital is much safer today.

Belfast Trust welcomes the publication of this Review and we will give it careful and detailed consideration.[1]

[1] BHSCT Press release 5 August 2020 https://belfasttrust.hscni.net/2020/08/05/belfast-trust-welcomes-the-publication-of-a-review-of-leadership-and-governance-at-muckamore-abbey-hospital/

Independent Review of Advocacy Arrangements in Hospital and Community Learning Disability Services in Belfast HSC Trust

Marie Roulston & Bria Mongan

February 2023

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Review of Advocacy Services

Acknowledgements

The review team would like to thank all those who gave so generously of their time to contribute to this review most especially the individuals and family carers who have lived experience of advocacy. Their views and experience informed our findings and recommendations.

The review team completed significant engagement with a wide range of external stakeholders including the organisations who are commissioned to provide Advocacy across Learning Disability services regionally.

The review team met with RQIA, NISCC, SPPG and DOH which provided the strategic and policy context informing the review findings.

The review team wish to thank the BHSCT Community Learning Disability teams across children's and adult LD services and teams based at Muckamore Abbey Hospital and the Iveagh Centre who provided rich information in regards to awareness, challenges and demands for advocacy.

The review team also benefited from meeting with the Telling It Like It Is (TILII) group who provided the review team with their experience as experts by experience and wish to thank the Association for Real Change (ARC NI) who facilitated the meeting with the TILII group.

The Directors in BHSCT and their senior management team actively engaged with the review team and provided significant documentation and advice relating to contracts and commissioning of Advocacy services.

The review team would like in particular to thank Caroline Morrow for her technical expertise in formatting the final report.

1 **Introduction**

1.1 The Belfast Health and Social Care Trust commissioned an independent review of advocacy arrangements across learning disability services following recommendations arising from a number of independent reports. The review was completed by co-reviewers, Marie Roulston and Bria Mongan (Associate Consultants HSC Leadership Centre).

1.2 The request for an evaluation of advocacy services was raised in the "A Way to go" report, the serious adverse incident report produced by Margaret Flynn following the emergence in 2017 of allegations of abuse at Muckamore Abbey Hospital (MAH) The report was shared with stakeholders in December 2018 and a summary of the report was published in February 2019. The Leadership and Governance review report into MAH published in July 2020, recommended that advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for patients and support for their relatives and/or carers.
Both reports address the issue of advocacy, with the "Way to Go" report describing the advocacy services within MAH as "not as uncomfortably powerful as it should be"

1.3 Research evidence highlights that Independent Advocacy can help individuals with learning disability to express their views and wishes and can help them to make informed choices and access information.
It can help them to feel listened to and feel more involved in decision making and can increase their confidence.

1.4 This review will consider research evidence, best practice, feedback from those with lived experience and the development in policy and legislation across the UK to inform our findings and recommendations for the development of advocacy services.

1.5 Aim of Review

The aim of the review is two-fold;

1. To understand the extent to which the current commissioned advocacy arrangements have the capability and the capacity to deliver against the principles of advocacy
2. To make recommendations for outcome measures which the Trust could use in the future to commission and evaluate advocacy services for patients, service users and carers, in order to move away from the existing output-based approach.

The Trust have requested that the review will look at this with respect to both carer advocacy and service user/patient advocacy.

1.6 Terms of Reference

The terms of reference are attached in appendix 1.

2. Methodology

2.1 A mixed methods approach was taken to ensure both qualitative and quantitative data was captured. The reviewers provided project updates to senior managers within BHSCT including director, co-director and lead social worker for learning disability which helped identify key internal and external stakeholders

The reviewers met with the stakeholders identified in section 2.2 and a number of Zoom and face to face meetings were held with each of these.

A questionnaire was devised and an easy-read version agreed for service users to capture the experience of stakeholders in regards to access and effectiveness of advocacy services.

A postal and on-line survey was conducted with families and carers, facilitated by Elizabeth Stephenson, engagement lead for learning disability services in BHSCT.

The questionnaires and survey used are attached in Appendix 2.

A review of the existing BHSCT contract with Bryson House was undertaken alongside a review of contract monitoring returns.

Examples of good practice were considered, both within Northern Ireland, Scotland and Wales.

2.2 STAKEHOLDERS

Internal BHSCT stakeholders comprised;
Anne O'Reilly Non-Executive Director on the BHSCT Trust board and champion for Learning Disability and Involvement.
Claire McMahon, Contracts Manager
Sandra McCarry, Lead for PPI
Elizabeth Stephenson, Engagement Lead for Learning Disability

BHSCT Teams interviewed comprised:

- Care management and Resettlement team;
- Day care and day opportunities team;
- Statutory supported living team;
- Adult safeguarding team;
- Residential services;
- Muckamore Abbey Hospital clinical team;
- Community AHP team;
- Community Learning disability teams;
- Iveagh team; and
- Children's community disability team

External stakeholders comprised

- Carers - BHSCT
- TILLI group (tell it like it is);
- The Directors of the 5 HSC Trusts
- SPPG
- Chief Nursing Officer - DOH
- Chief Social Worker-DOH
- Patient Client Council;
- ARC
- RQIA
- NISCC

- Bryson house;
- Mencap;
- Disability action;
- Voypic

3. Legislation and Policy Context

3.1 In this section we will critically evaluate the legislation and strategic policy context across UK nations to identify models of good practice in regards to advocacy for people with a Learning Disability and look specifically at the policy direction in Northern Ireland relating to Advocacy Services.

3.2 The policy direction in Northern Ireland has been influenced by a range of inter-related legislation, policy and reports arising from independent reviews.

There has been widespread public concern about the experiences of people with a learning disability following disclosures of abuse in a number of learning disability hospitals and community facilities across the UK, prompting revised Learning Disability strategy elsewhere in the UK.
The ongoing investigation of abuse at MAH has again highlighted the need for advocacy services to ensure that the voice of people with a Learning disability is heard.

3.3 Whilst Advocacy services are implicitly referenced in a range of policy documents and service reviews in Northern Ireland, there has been no updated regional strategy for Learning Disability Services since the Bamford review 2002 and Equal Lives report 2005.

An Independent review of the Learning disability resettlement programme in Northern Ireland (July 2022) recommended that the DOH should produce an overarching strategy for Learning Disability services with co-production built into all levels across the HSC system and the development of a clear pathway for advocacy services which values different forms of advocacy to include independent advocacy, self-advocacy and the role of family carers.

The second report from the Bamford review, “Equal Lives” published in 2005 has been the key strategic driver shaping delivery of services for individuals with a learning disability over the past 25 years. Equal Lives concluded that progress needs to be accelerated on establishing a new service model based on integration, where people

participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else.

This requires responses that are person centred and individually tailored; ensuring that people have greater choice and more control over their life; that services become more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important; increased flexibility in how resources are used; balancing reasonable risk taking and individuals having greater control over their lives.

Recommendation 56 from the Equal Lives report highlighted the underdevelopment of independent advocacy and the role of advocacy in bringing about change in the way systems work with individuals. The principles and values underpinning the Bamford "Equal Lives" report remains relevant today.

3.4 Delivering the Bamford action plan 2012-2015 included the implementation of mental capacity legislation. The Mental Capacity Act (2016) includes appropriate safeguards to decisions about care that have to be made for those unable to make decisions for themselves. In particular, the Act will provide for the appointment of independent mental capacity advocates when fully enacted and this duty will require to be considered within the context of this review to address capacity and capability of advocacy services and clarification of role and function.

The principle of involving people in decisions about their care to ensure that the lived experience of service users and their family carers shape service development has been embedded in policy for many years.

The 1992/1997 Department of Health and Social Services regional strategy "Health and Well Being into the New Millennium" 2012, highlighted the importance of the right approach in planning, designing services in partnership with people who use services through co-production and in addition, strengthening the user voice.

The "Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003, applied a statutory duty of quality on the HSC Board

and Trusts. The Quality standards for Health and Social Care launched in 2006 included a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

The Health and Social Care (Reform) Act (2009) placed a statutory duty on Health and Social Care organisations to involve people in the planning of services.

Transforming Your Care' was published by the Minister for Health, Social Services and Public Safety (DHSSPS) in 2011. A draft Strategic Implementation Plan was developed to drive forward the recommendations in terms of learning disabilities with a focus on resettlement, delayed discharge, access to respite for carers, individualised budgets, day opportunities, Advocacy and Directly Enhanced Services (DES)

The Department of Health (DOH) 'Co-Production Guide for Northern Ireland (2018) recognised that co- production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

DHSSPS published HSC service frameworks for key services including learning disability launched in 2013 and revised in 2015, setting out 34 standards in relation to thematic areas including standard 9 which states;" service users and their carers should have access to independent advocacy as required"

3.5 RQIA have published a number of reports which reflect the value and importance of advocacy services.
In 2009, RQIA established an Advocacy forum to bring together provider organisations sharing best practice informing RQIA inspections.

In March 2012, RQIA published a review of the Provision of Advocacy Services in Mental Health and Learning Disability Inpatient Facilities in Northern Ireland. This review concluded that there was a significant amount of work to be done with regard to ongoing policy development relating to advocacy, stating that provision was patchy across Northern Ireland. The report set out the legislative framework, the differing

types of advocacy and the role of Advocacy in Safeguarding rights and promoting choice. The report also raised the concept of "Independence" noting that some advocacy providers are employed by organisations which also provide accommodation and care services to HSC Trusts. The report noted that the level of training varied greatly amongst advocates and highlighted the importance of not using all available resources on statutory advocates at the expense of peer led advocacy.

In February 2013, RQIA published the report of a review of Safeguarding Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland. This review recommended that HSC Trusts should ensure that patients and relatives on all wards should have access to advocacy services. RQIA identified a number of constraints highlighting that there was no clear statutory duty or strategic framework, a lack of resources and no process for regulation of advocacy providers.

As part of RQIA's review programme 2015-18, DHSSPS asked RQIA to undertake a review of the commissioning arrangements for advocacy services for children and adults in Northern Ireland to consider whether commissioning was in keeping with the principles and standards set out in "Developing Advocacy services" DHSSPS policy guide 2012.

RQIA's Review of Advocacy services for Children and Adults in Northern Ireland January 2016, made a total of 8 recommendations for improvement focused on an assessment to determine future capacity requirements, improve access to advocacy, improve cross agency working, evaluation of advocacy services and the consideration of a regulatory framework. The review noted that commissioning was focused on outputs rather than outcomes and recommended that HSC organisations work with independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services and to inform future commissioning.

3.6 The Department of Health and Personal Social Services (DHSSPS) published 'Developing Advocacy Services, 2012 – a Policy Guide for Commissioners'. To help commissioners better understand and develop advocacy services. The guide introduced principles and standards to underpin the future commissioning and delivery of all HSC advocacy services. This document set out six principles for those

organisations who commission advocacy services, regardless of the type or model of advocacy being commissioned. These principles are set out below:

1. Accountability
2. Independence
3. Empowerment and enablement
4. Evidence based approach
5. Shared learning
6. Quality and Effectiveness

The Policy Guide suggests that an evaluation framework should be developed that would include advice on processes and tools for gathering and analysing information on outcomes and for measuring this against the principles and standards in the document. Such a framework, it was envisaged, could be used for self-assessment and/or external evaluation purposes.

Section 9.8 provides guidance on evaluation. It states that evaluation should, as a matter of good practice, seek to take into account, the perspectives of all stakeholders and that it is important to seek the views of as wide a group as possible – those who need advocacy, paid and volunteer advocates, management and staff of the organisation providing the advocacy service, the commissioners and referrers where appropriate. Evaluation should be outcome focussed.

Unfortunately, it does not appear that a framework was developed.
This guide remains relevant today and will inform the recommendations arising from this review.

3.7 The Advocacy Network Northern Ireland (ANNI) was established in 2012, with the aim of providing opportunities for Independent Advocacy organisations to share best practice, share training and development opportunities and promote independent advocacy.

Following the publication of the Department's Guide and associated action plan, the HSCB commissioned ANNI to develop documents to support the implementation

process resulting in a Code of Practice along with a standards framework and core induction checklist. The Code of Practice for Independent Advocates was published in 2014.

3.8 The effectiveness and need for a regional Advocacy network were raised by a range of key stakeholders during engagement events with the review team. Feedback from providers of Advocacy services, highlighted that the independent advocate workforce in each organisation can be relatively small, working in complex environments and addressing complex issues.

The review team received comments on the merit in having a regional shared platform for standardising advocacy practice, raising the profile and development of Independent advocacy as a profession.

The HSCB acted in the past to facilitate the development of ANNI which did not appear to sustain beyond the commissioned work and support of a time limited project manager. Consideration now needs to be given to the appropriate mechanism to support a regional Network and build sustainability.

There are a number of options that could be considered in partnership with Regulatory bodies, Patient Client Council (PCC) HSC Trusts and the Strategic Planning and Performance Group (SPPG)

3.9 Further to legislative and policy direction in Northern Ireland, there have been a number of independent investigations following disclosure of abuse to patients at MAH in 2017 that have addressed access to and the effectiveness of current advocacy services.

The Serious Adverse Incident investigation report, 'A Way to Go', noted that advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'.

The report also acknowledged that 'episodic contact is unhelpful' which also raises the question of how family members, where they exist, are supported to act as the primary advocate for their loved one, through being ongoing and active partners in their care.

A further independent Review of Leadership and Governance at MAH (August 2020) recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

3.10 In 2018, the Department of Health established an Implementation Plan to take forward the recommendations arising from the Inquiry into Hyponatraemia Related Deaths (IHRD). Workstream 7 of the IHRD Implementation Programme is tasked with considering the following recommendation:

'A fully funded Patient Advocacy Service should be established, independent of individual Trusts to assist families in the process and allow funded access to independent expert advice in complex cases.'

The Independent review of the Resettlement programme in Northern Ireland (July 2022) recommended that HSC Trusts should develop a clear pathway for Advocacy services valuing and recognising the differing types of advocacy.

This review team also reviewed the learning from policy in other UK regions relating to Advocacy services.

3.11 Wales

The Welsh Government in May 2022, published an Action Plan (2022-2026) which sets out the strategic agenda for the development and implementation of learning disability policy building on the Improving Lives programme, including a strategic priority for Advocacy, Self-advocacy, engagement and collaboration.

The Welsh Government published part 10 Code of Practice (Advocacy) in December 2015, updated December 2019 which relates to the Social Services and Well-Being (Wales) Act 2014

In regards to commissioning, the Code states;

- The independence of the advocate is essential and as far as possible advocacy services should be funded and managed in a way that ensures independence from the commissioning organisation.
- Local authorities should co-ordinate commissioning on a joint or regional basis contributing to the delivery of value for money for commissioners and sustainability for providers.
- The Code recognises a number of different statutory provisions which impose requirements about advocacy including the appointment of an Independent Mental Capacity Advocate and fact that there may be occasions when different entitlements to advocacy overlap. Consideration should be given to maximising continuity however, exercising caution when instructing a single advocate to fulfil more than one advocacy entitlement. The Code highlights the need for advocates to liase to minimise duplication.

The principles set out within the Social Services and Well-Being (Wales) Act 2014 and the Regulation and Inspection of Social Care (Wales) Act 2016, the Regulated Advocacy Services (Wales) Regulations 2019, inform the Care Inspectorate Wales 'Inspection framework for regulated advocacy services' (July 2019)

The learning from recent developments in legislation and policy relating to Independent Advocacy in Wales, include the need to consider regional commissioning and the added Safeguards associated with regulation and inspection of Advocacy. These strategic themes have been raised in a range of inspection and service review reports in Northern Ireland and require to be further analysed and addressed in this review.

3.12 Scotland

There is significant learning also from the Scottish Government's approach to citizenship and involvement. 'A Stronger Voice' scoping study of Independent

Advocacy for people with Learning Disability, 2018 (Scottish Commission for Learning Disability states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made
- Be involved in decision making processes
- Become more confident and able to self-advocate

The Scottish Government published 'Independent Advocacy Guide for Commissioners 2013.

The Scottish Independent Advocacy Alliance (SIAA) is a membership organisation which promotes and defends independent advocacy in Scotland. The SIAA developed Principles and Standards for Independent Advocacy (2008) The standards highlight that advocacy should be provided by an organisation operating independently from other service providers involved in the treatment and care of the individual and attention also needs to be given to sustainability of provider organisations.

SAII in 2010 published "Independent Advocacy; An Evaluation framework" offering tools for evaluation of advocacy services. Independent Advocacy: an evaluation framework - Scottish Independent Advocacy Alliance.

Themes arising from the scoping study were reflective of the themes, concerns and barriers raised with this review team in meetings with a range of statutory and voluntary sector stakeholders in Northern Ireland.

The landscape for advocacy provision is complex with considerable variation in the type of advocacy support which is accessible. Demand has increased in some areas of practice resulting in prioritisation of the resource currently available with a focus on statutory obligations and resettlement/ hospital in-patients with limited awareness of availability or how to access advocacy for those living in community settings.

There was mixed experience of using advocacy services and a lack of awareness of the role of the advocate. Difficulties in capturing soft outcomes together with differing

understandings and interpretations about the role of the advocate presented challenges to effective evaluation.

3.13 England

Commissioning independent advocacy under the Care Act in England published October 2014 and updated October 2022, summarises good practice in advocacy.

Key messages highlight that commissioning integrated advocacy, offers easier access to multi-skilled advocates, and the need to develop outcome focused specifications and contracts.

Commissioning independent Mental Health Advocacy (IMHA) services in England published March 2015, provides 10 top tips for commissioners.
Understanding the role and responsibilities of IMHA and other forms of advocacy is important.in addition to a focus on outcomes-based commissioning.

"Advocacy for people with a learning disability and autistic people in mental health in-patient services" Voice Ability (March 2022. This paper sets out the case for a nationally commissioned, specialist advocacy service for people with learning disability.

The paper presents evidence that whilst advocacy services can be an important resource, the quality of support is too variable. The paper concludes that a national commissioning model would enable a higher quality advocacy service to achieve better outcomes for people with learning disability

According to the Challenging Behaviour Foundation, independent advocacy is a crucial resource that can ensure choice, well-being and enable person centred care.

However, a recent report from Care Quality Commission (CQC) found that access to high quality advocacy varied across hospitals and that the role of the advocate was not consistent. In some cases, there was no evidence that advocacy had been offered to people.

Advocates were also under pressure and felt they did not have enough time to advocate fully for people and were asked to increase input but no additional funding made available.

Heightened risks of abuse, prolonged detention without therapeutic benefit and delay in hospital discharge have been an enduring concern. To be effective in these circumstances, an advocacy service needs highly skilled staff with experience of working in environments with heightened safeguarding risks increasing the case for national commissioning.

NICE guideline on Learning Disability and behaviour that challenges recommend that advocates have appropriate skills and that national commissioning would provide greater accountability and enable providers to develop a critical mass of highly skilled and experienced advocates with more tailored professional support and supervision

"Supporting People with a Learning disability or autism who display behaviour that challenges including those with a mental health condition (October 2015)- Service model for commissioners of HSC -Local Government Association- ADASS -NHS England also makes the case that both statutory and non-statutory advocacy should be delivered by services that are independent of the organisations providing the person's care and support.

The case for independent advocacy has been embedded in Learning disability policy for decades however operationally, access remains patchy and prioritised to statutory requirements associated with Mental Capacity legislation.

3.14 Republic of Ireland

The Disability Act 2005 provides an entitlement to advocacy for persons with a disability and the Citizens Information Act 2007 provides for the establishment of a personal Advocacy service.

The National Advocacy service was established in January 2011 following legislative commitment in Comhairle Act 2000 and the Citizens Information Act 2007 to provide

independent representative advocacy services for people with disabilities. The service is regionally structured with five regional teams across the country and funded by the Department of Employment and Social Protection through the Citizens Information Board while statutory funding for other independent advocacy services at national and local levels are provided by the HSE. The Patient Advocacy Service is an independent service to support people who want to make a complaint or challenge an experience they have had in an HSE funded hospital or HSE operated home. The HSE also fund a range of patient advocacy groups.

Safeguarding Ireland published a scoping document in September 2018 setting out the key factors underpinning advocacy and the current position in Ireland. The paper highlights that advocacy practice has a proactive or safeguarding role as well as an empowering dimension. The paper proposes that a National framework for independent advocacy is required and need for a stronger legislative framework.

The analysis of policy developments across UK regions and ROI along with feedback from key stakeholders to the review team, highlighted common themes and previous recommendations including;

3.15 Key Points

- The requirement to carry out a Needs assessment to determine capacity requirements.
- Consideration should be given to a regional approach to commissioning advocacy services
- A regional forum bringing together advocacy providers should be considered given the evidence provided to the review team of the value and effectiveness of the Advocacy Network Northern Ireland (ANNI) in standardising standards and training of advocates
- HSC Trusts should work with Independent advocacy providers to develop outcome measures in service agreements to enhance the evaluation of advocacy services
- Consideration should be given to the regulation of advocacy services

- HSC Trusts should work with Advocacy providers to develop a pathway and triggers to prompt referral to independent advocacy
- Advocacy support should be available and strengthened at all stages of care planning and automatically offered in all safeguarding investigations
- HSC Trusts must ensure that there is a clear pathway and clarification of roles developed when additional Independent Advocacy services are in place to support either the person with Learning Disability or family carers.
- Emerging recommendations relating to the development of advocacy services arising from the workstreams associated with the Hyponatraemia review, the Mental Capacity Act and programme of care specific requirements and the skills required for each function need to be carefully mapped out to avoid duplication and confusion.

4 Current Advocacy Provision within Belfast Trust

4.1 Belfast Trust currently have a contract with Bryson house for the provision of an independent advocacy service. The contract is longstanding, having been rolled over year on year since 2014

In 2020/2021, the funding for the contract was £83,816.

The focus of the contract is data-driven as opposed to outcomes focused and is set out in numerical terms.

The funding is to provide 75 hours per week – 50 hours within the community and 25 dedicated to a service within Muckamore Abbey hospital for patients from the Belfast Trust and also the South Eastern Trust.

This amounts to a total of 2,850 hours over 38 weeks.

4.2 In 2017/2018, an additional amount of funding was allocated to the contract to secure an additional 1,900 hours. The specification for this additional allocation was very specific:

1. to run a carers advocacy pilot;
2. to complete Quality of Life assessments (QOL) within Muckamore; and
3. to pilot a “have your say group “within Iveagh hospital.

Again, the specification focuses on numerical data and not on outcomes. That is:

- 25hours allocated to the carer pilot, 3 attendees per week;
- 16 hours per week for QOL assessments for all patients transitioning out of Muckamore; and
- 9 hours per week within Iveagh for young people resident less than 3 months.

4.3 The monitoring returns reviewed were again very numerically driven with a focus on activity with no qualitative data whatsoever as to the outcomes for any individual receiving a service.
There is no information on the number of advocates, the skillset of the advocates, the training and development needs or on recruitment.

There is a process for the monitoring of contract returns and they are signed off by the service lead before being submitted through to the contracts department.

There was a consensus that there was a need to consider how best to develop an outcomes-based approach to allow for much more qualitative data and evidence of impact.

Undoubtedly, Covid has had an overall impact in terms of face to face meetings with the advocacy provider. However, there was a sense of frustration and concern as to the rolling over of contracts year on year. The provider described the uncertainty that this brings to the service and also introduces additional vulnerability in terms of retaining and recruiting staff.

Current Advocacy Provision for Children and Young People at Iveagh Centre

4.4 Iveagh is a specialist regional hospital for children and young people with severe learning disability and challenging behaviour. Situated in Belfast, it provides treatment to a small number of children across the province.

As part of the existing contract held with Bryson House, an additional amount of funding was allocated on the understanding that a pilot would be undertaken within Iveagh hospital with the formation of a “have your say group”

This funding remains in place and is part of the overall contract with Bryson however there was a general consensus that this doesn’t really meet the full range of needs of the young people within Iveagh.

4.5 We interviewed the team within Iveagh, the children's disability team, VOYPIC and Bryson with respect to this contract.

It should also be noted that there is significant use of legal advocacy within Iveagh as a number of parents were engaged in judicial reviews pertaining to delayed discharges.

4.6 As with the main contract, there is a confusing picture within Iveagh. Bryson and VOYPIC both provide an advocacy service with Bryson providing the initial service and handing over to VOYPIC following a 3-month period. The view of the team was that the strength of the advocacy was variable, it didn't appear to challenge and was possibly more robust for the carer rather than the individual young person.
The view of the team in Iveagh, was that the commissioning of a child specific service would better meet the needs of the young people recognising the complexity and communication needs of the young people.

4.7 The children's community disability team concurred that there was a specialist skillset required to advocate for these young people and also felt that at times the advocacy role was seen to be for the parents and not the individual child. They stressed the need for good communication skills. This team also felt that a discreet children's advocacy service would work best.
The team however were aware of the role of Bryson and Voypic and had a good understanding of this and felt that an advocate was able to ask "the elephant in the room question "

4.8 VOYPIC hold the regional contract to provide advocacy support to looked after young people across the province and they have a youth rights worker who links directly with Iveagh. Again, they recognised the need for a very specialist skillset to advocate for these young people.

4.9 There is a model with a dedicated advocate in Beechcroft (Child and Adolescent regional in-patient unit) through VOYPIC and this could be a possible model to explore going forward.

In the meeting with Trust directors, they agreed that there was a distinctness and difference in advocating for young people reinforcing key issues such as transition planning.

Bryson confirmed they had a patient advocate located within Iveagh and identified key issues around transition planning and discharge and again identified the challenge of advocating for parents or the young person, noting their view that there is a lack of advocacy for parents and carers.

4.10 Key Points

1. Current contract doesn’t meet the needs of the young people within Iveagh.
2. The skill set and training required to communicate effectively with children with learning disability including those who are non-verbal needs to be specified.
3. Consideration should be given to commissioning a child specific advocacy service for young people with a disability who may enter Iveagh and for those receiving learning disability services in the community.

5 Awareness of Advocacy and access-

Feedback from families about their experience of Advocacy services-
Patient and User stories

5.1 The review team extended an invitation to families in contact with BHSCT Learning Disability community services or MAH to meet the review team to discuss their lived experience of and expectations of Advocacy services.

5.2 The review team would like to thank BHSCT engagement officer for her assistance in issuing the invitation through existing BHSCT engagement forums, newsletters and through a variety of social media and communications used regularly by BHSCT to circulate information to families about learning disability services.

5.3 The response was limited to families who are more regularly linked into attending BHSCT engagement forums.
It would appear that families are experiencing consultation and engagement fatigue and reserve engagement for events or issues that directly relate to care planning for their individual family member. Having said that, the review team would like to thank the families who did meet with the review team. Their lived experience, information and guidance provided to the review team was rich and informative. There were common themes arising from engagement with and feedback from family carers which included;

5.4 Key Points

- the importance of the review extending to address advocacy beyond the services directly commissioned, to include the role of family members giving voice for loved family members.
- Families strongly expressed the view that a loving family member or trusted person in the family circle is well placed to advocate
- Families not feeling listened to or valued as partners in care
- Empower families to be involved-Partnership working critical

- The importance of Advocacy services being seen to be independent with no conflict of interest
- Turnover of key worker staff has impacted on continuity and the role of the key professional staff member acting as an advocate
- Lack of awareness of advocacy for many families. No guidance for families
- Communication remains a challenging area despite the steps taken by BHSCT to establish an infrastructure of forums with dedicated engagement staff
- Families recognised that a second opinion can be helpful as family can be led by emotions/ the heart rather than the head. Some families also recognised that family can have zero tolerance for risk
- Families expressed the view that organisations can perceive family challenge as threatening
- Families also raised the skill set required for effective advocacy

5.5 Family carer's lived experience of Advocacy Services

A family during engagement with the review team, talked about their experience with advocacy which has not been a positive experience. As a consequence, the family felt strongly that they are the strongest advocates in speaking up for their son. The family expressed confusion as there had been 2 advocates involved at times and they were unclear about their respective roles. Family did not know why the advocates had become involved and advised that their view was not sought on the matter. The family advised advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family felt that they are the only ones in their son's life for the long haul and that they will continue to be the strongest voice speaking up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son and wish to see the role of the family as advocate valued and respected.

One family advised that they did not trust the independent advocate and acted as advocate themselves.

Another family carer advised that she had not been aware that independent advocacy was available.

Whilst the number of families meeting directly with the review team were small in number, the majority had long standing experience of a loved family member being in-patient at MAH for lengthy periods and also had experience of transition to community services.

5.6 A recurring theme shared with the review team, was a sense of confusion and lack of awareness about advocacy services which directly impacts on access. Families stated that they are not aware of any guidance document developed for families and felt that a clear pathway was needed clarifying roles, skills/competencies and thresholds for referral.

5.7 Feedback from people with a learning disability was gained through engagement events between the review team and TILLI group facilitated by the Association for Real Change (Arc NI)

5.8 TILLI made a strong case for peer advocacy making a difference at both population and individual case level. Individuals who have completed training, reported that they have gained confidence in speaking up and communicating.

5.9 Examples of Good Practice: PEER ADVOCACY

Peer advocacy refers to; "one to one support provided by advocates with a similar disability or experience to a person using services"

As part of the overall engagement plan, the review team met with some members of the Belfast TILLI group (Tell it like it is). The group is facilitated by Louise Faulkner (ARC) and there are groups in three of the 5 trusts.

This was a really enthusiastic engaging group of individuals who clearly articulated the benefits of peer advocacy. TILLI is a strong example of how peer advocacy can work very well within Northern Ireland.

The group were well informed about advocacy but whilst all were resident within the Belfast Trust area, none of them were aware of the advocacy service provided through

Bryson, one lady had lived within Muckamore and is now living in a sheltered setting, she thought she may have had an advocate at one point but wasn't sure.

When asked if they needed help with anything who they would turn to, each of them named Louise, the group facilitator.

The group described how being a member of the group has increased their confidence, given them new experiences, has helped them to speak out not only for themselves but for others less able to do so and it has given them courage.
The facilitator described the work the TILLI group do, not just as peer advocates but how they work on developing easy read documents, produce videos on difficult and complex issues. The commitment shown by Louise and her creativity in maintaining relationships throughout Covid is exemplary and does make this an example of good practice.

There are other models of peer advocacy across N. Ireland.

5.10 Key Points

- Peer Advocacy has a strength in ensuring the voice of individuals is heard and BHSCT should engage with other HSC Trusts to share this model of good practice.
- Peer Advocacy empowers individuals
- Peer Advocacy needs to be embedded in a continuum of Advocacy options

5.11 Access to Advocacy services -Raising awareness

BHSCT have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) which includes a 'Communication and Engagement plan', the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers.

The engagement lead shared the terms of reference for a range of learning disability

engagement forums with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about a range of issues including transitions and accommodation.

The review team met with both the forum for MAH families and the forum for BHSCT community learning disability services to discuss their experience of and views on advocacy. There are only a small number of the MAH families actively involved in the MAH forum.

It is clear that BHSCT has worked to develop an infrastructure to support engagement with service users and families however, the process is at an early stage and will require further development to ensure that communication with all families is effective in raising awareness and access to Advocacy services. Some of the families who have had loved family members transition from MAH to community placement did not recall being offered advocacy. Some families attending the community learning disability forum also advised that they are not aware of advocacy services or how to access.

5.12 Feedback on awareness from Trust staff

As can be seen from the methodology, the review team met with a significant number of teams across the Belfast Trust, and we thank all of the staff for their time. Overall, professionals were interested in the review of advocacy and there was a general recognition that more needed to be done in terms of providing independent advocacy.

5.13 Awareness did vary across teams with those teams directly linked to Muckamore having a greater awareness of the contract. There were examples of good practice shared and there were other community teams who understood the contract only to be for patients in Muckamore and not the wider community-based population.

5.14 The Care and Resettlement team had positive experiences of advocacy, where advocates had been part of the resettlement process, however staff were unaware of any Trust policies with respect to advocacy.

This team also expressed concern as to the “independence “of the advocate, who was sometimes perceived by families as being “part of the team “.

5.15 Practitioners very much welcomed the challenge function which the advocate brings but also expressed concern as to the lack of outcomes measures. A positive example was given where an advocate had successfully supported a service user in negotiating contact with her new born baby, working with a family and child care team to ensure the service user views were listened to. The advocacy role was seen to be very valuable in situations where there was the potential for conflict or controversy.

5.16 The role for advocacy in fulfilling the Mental Capacity act was raised by a number of professionals, and the need to develop advocacy services highlighted several times.

5.17 The staff working within day care settings described how they provided an advocacy role within their centres and whilst aware of the contract with Bryson House, believed this service was not available to their service users. They could see where the role of an independent advocate could be of added value particularly around transition planning for young people leaving school.

They also gave an example where a service user wanted to reduce her time at the centre and displayed this clearly through her behaviour, but parents were reluctant. The staff felt an independent advocate in this instance could have been beneficial in supporting the service user to have her voice heard.

5.18 Examples of “club committees “were cited as the “true essence “of peer advocacy, 3 clubs in Belfast were noted as being “run by folk with learning disability “for “folk with disability.

5.19 Within supported living, there was a recognition of the value of independent advocacy and an acknowledgment that where a referral was made for advocacy, the service was provided. There was a view however, that many others could avail of the service but there was limited capacity.

5.20 There was a recognition that increasingly, advocates should be skilled and experienced in human rights, and a recognition that “one size doesn’t fit all “so the skillset of advocates was important.

Within the short break service, particularly with the reopening of services post Covid, teams thought that advocates should have had a critical role but capacity appeared to be an issue.

5.21 The adult safeguarding team and the clinical team within Muckamore were very aware of the role of Bryson providing an advocacy service for BHSCT and SEHSCT patients and also of Mencap providing advocacy service to Northern Trust patients with respect to admissions to Muckamore. Disability Action provided advocacy for Southern HSC Trust patient in Muckamore. There was a clear understanding that an advocate was appointed on admission, however there was acknowledgement of an identified gap in judging the effectiveness of the service and in the coordination and standardisation of Advocacy services across the range of providers.

They were also unsure if there was a wider Trust policy.

5.22 Some advocates have been involved with their service user for a long time and there was a discussion about the time needed to build a relationship with the service user. Skills in communication and managing challenging behaviour were seen as essential to the skillset. These teams also raised issues of induction training for advocates and the need for both consistency and continuity were important.

5.23 In-Patient teams were in a position to discuss the challenge function of independent advocacy. Whilst staff recognised the importance of challenge, staff also discussed that this can be difficult due to the emotional issues, conflicting needs and complexity of cases.

5.24 Iveagh and MAH teams also recognised the interface with legal advocacy and increase in the number of families seeking to challenge through the court process. There were also some examples where advocates had been very responsive, easily accessed and secured positive outcomes.

5.25 Summary of key points

- Awareness of the level of Advocacy resource available and thresholds to prompt access to advocacy was variable across teams with community teams generally having less experience or awareness
- Processes by which advocacy is made available are not sufficiently clear
- There were positive stories depending on team setting, examples of where advocacy had made a difference to an individual
- Lack of trust policy and protocol
- No effective measurement of outcomes
- Need for induction training and ongoing training for advocates
- Recognised skillset for advocates to include experience in human rights work
- Staff in both in-patient and community settings highlighted the importance of communication skills with this client group and need for advocates to be suitably trained or to be supported by the multi-disciplinary team
- Capacity issue, advocates could be used much more across the service.
- Promoting the full range of advocacy needs to be supported by organisational culture and training for all staff to enable them to accommodate challenge
- Potential to coordinate and standardise advocacy practice across a range of advocacy providers

5.26 Review of Advocacy: Outcomes Measures

Within the terms of reference, the reviewers are asked to consider meaningful outcome measures.

As referenced in the body of the report, the current contract and the monitoring of the contract is very much based on outputs rather than outcomes. The contract does monitor the number of people who access advocacy and to some extent captures unmet need but there are no unified outcomes to measure for example;

- how better informed was the service user as a result of advocacy support
- was the service user more independent or empowered as a result of the advocacy service?
- did the service user feel listened to and involved in decision making?

- were they less socially isolated
- was the risk of harm reduced?

5.27 The development of meaningful outcome measures should be done alongside those with lived experience including a group such as TILLI and there are a number of toolkits available to assist with the development of outcome measures and evaluation

If one of the recommendations from the review is the development of meaningful outcome measures, a regional strategic overview should be considered.

5.28 In essence, the current contract doesn't measure if the role of the advocate is making a difference to the service user and this should ultimately be the main aim of the service.

6 Commissioning, Challenges and Future Requirements

Commissioning

6.1 The HSC Trusts are the main commissioners of advocacy services for learning disability services in Northern Ireland and most contracts in place have rolled over year on year.

6.2 The BHSCT Trust appears compliant with procurement relating to social care procurement as all contracts are below threshold and fall within a "light touch regime" DOF policy,
"Procurement of Social and Other Specific Services" (2021) which sets out the procurement rules for contracts with a value greater than £663,540. The light touch regime provides considerable discretion to design the procurement process to take account of the individual nature of social care and other specific services.

6.3 The Trust contracts in place are based on activity and outputs and not on outcomes. The Trust provided evidence to the review team of contract monitoring through proformas, the requirement for providers to submit quarterly activity data and bi-annual contract review meetings however, the process is based on the number of people supported and does not provide the evidence required in regards to positive outcomes and Value for money. The review team did not see evidence that BHSCT sought assurance that the service is effective in making a difference in the lives of those supported.

6.4 The value of the contracts issued by each HSC Trust is small and that presents a challenge in regards to reach and impact. The research evidence suggests that critical mass is required to ensure the capacity and range of skills required to meet advocacy requirements in the developing range of sector and legislation specific advocacy.

6.5 In regards to commissioning, no evidence was provided to the reviewers that an assessment of need has been completed to determine the demand for advocacy services which should be central to commissioning and procurement.

6.6 Future commissioning will need to take into account, wider public policies, Strategy, legislation and guidance to inform advocacy commissioning decisions.

6.7 Recommendations arising from the Inquiry into Hyponatraemia-related deaths and the Mental Capacity Act (Northern Ireland) 2016 will increase demand for advocacy from differing programmes of care.

6.8 The principles and standards for advocacy across the full range of issue specific advocacy will be similar, even though the skill set will be tailored to the legislative context and the needs of the individual and their communication requirements.

6.9 The policy direction in other UK regions, recognises the requirement to consider national/regional commissioning to ensure Value for Money and standardisation through the development of quality standards and outcome metrics which can then be applied within assurance processes undertaken at a local level.

6.10 To support strengthened commissioning, there needs to be a refocus on the quality of data and information to support effective analysis and evaluation.

6.11 Challenges/ Future Requirements

6.12 Advocacy services have remained static with contracts rolling over for many years creating uncertainty for provider organisations. Access to advocacy has remained largely focused on those in hospital or transitioning from hospital with limited access or uptake from those living in the community.

6.13 Future commissioning will require to take into account the broad range of advocacy needs, inclusive of statutory, non-statutory, peer advocacy and self-advocacy

6.14 An Assessment of need should be completed and the process engage stakeholders to identify gaps in provision.

6.15 Advocacy services are not promoted/ signposted and there has been no Guidance developed for staff or service users/ carers. Guidance is required for service users/carers and staff.

6.16 The review team did not see evidence of training for staff in regards to working with and facilitating advocacy. The organisational culture required to commission and foster effective challenge by advocates has not been reviewed or tested and will require further consideration.

6.17 The review highlighted the importance of advocacy providers being seen to be fully independent with no conflict of interest. Contracts and specifications for advocacy should support advocacy providers to maintain their independence and specify that the service provided should be person centred and safeguard the individual.

6.18 Commissioners should involve people who use advocacy services in planning and designing services including in monitoring contracts.

No evidence was provided that BHSCT has an overview or analysis of the main concerns raised by advocates to inform improvement

6.19 There has been no review or update of the regional standards and there is no overarching advocacy policy at department level.

6.20 There is a lack of clarity in regards to the training level required for advocates with no review or update in regards to the skills required for new areas of demand

6.21 RQIA "Review of Advocacy services for Children, Young People and Adults in Northern Ireland" Inspection report January 2016, found that there was no clear statutory duty or strategic framework for independent advocacy, a lack of resources and no process for regulation of providers or for Advocates. This remains the case.

The findings from the RQIA report 2016 remain outstanding;

- Carry out Needs Assessment to determine future capacity requirement
- Develop outcome measures on service agreements
- Enhance evaluation of advocacy services
- Review and clarify arrangements for advocates to link with other sectors
- Review access and continuity cross HSC Trust boundaries
- Resource and training implications arising from MCA
- Explore potential of regulation and regulatory framework

6.22 Standards

6.23 Independent advocacy organisations share the same principles but it remains the responsibility of independent advocacy organisations and commissioners to put measures in place to ensure that the principles, standards and code of best practice is adhered to and to ensure that advocacy is being delivered consistently to the highest possible standard.

6.24 Best practice highlights that co-production with those accessing advocacy maximises the effectiveness of independent advocacy

6.25 In May 2012, a guide for commissioners (Developing Advocacy Services) and an associated action plan where published by the Department of Health, Social Services and Public Safety (DHSSPS) to help commissioners better understand and develop advocacy services in Northern Ireland. The guide introduced principles and standards and recognised that they may need to be tailored to meet the needs of specific client groups.

6.26 In June 2014 The Advocacy Network Northern Ireland (ANNI) published a Code of Practice for Independent Advocates

6.27 In 2019 The Scottish Independent Advocacy Alliance (SIAA) published 'Independent Advocacy Principles, Standards and Code of Best Practice to be used

across Scotland to ensure that independent advocacy was being delivered consistently. The document aims to safeguard independent advocacy by setting standards and promoting best practice and has a safeguarding role ensuring people that access independent advocacy can have confidence in the help and support they receive.

6.28 Safeguarding Ireland published a scoping document in September 2018 on the current context and future challenges in regards to Independent Advocacy in Ireland. The document aims to provide a context for developing an informed and common understanding around the language and concepts relating to advocacy in order to identify clear pathways for development of advocacy.

The report highlighted six points;

- Importance of having a clear understanding of what advocacy is, where it fits in the overall social supports infrastructure and who is likely to need and benefit from advocacy
- Important that underpinning principles of advocacy are identified and explored
- Social and legislative context should be understood
- Advocacy practice has a protective or safeguarding role as well as empowering dimension
- Whilst HSC professionals have an advocacy role there is an important distinction between advocacy role of professionals and independent advocates

6.29 Advocacy is underpinned by a core set of values, principles and standards.
If people lack capacity or have profound communication difficulties, they may have a greater need for independent advocacy and may need to draw on different types of advocacy for different needs.

6.30 Safeguarding Ireland's scoping paper also explores the role of HSC staff in advocating for service users and reflects that the code of practice stipulates advocacy as a key function for Social Workers.

6.31 In Northern Ireland, the standards of conduct and practice for social workers includes the following stipulation; “supporting service users and carers to communicate their views, needs and preferences, advocating on their behalf where appropriate”

6.32 This review highlights the need for the role of HSC Key workers in regards to advocacy to be included in the continuum of advocacy pathway and consideration given to capacity and competencies within the key worker role.

6.33 Advocacy standards nationally and internationally are based on a broad common understanding of what advocacy is, although ownership of standards in advocacy has been inconsistent.
A number of advocacy standards documents are relevant in the NI context for example, the Scottish Independent Advocacy Alliance developed Guidelines for non-instructed advocacy and notes advocacy practice, standards, skills and competencies as;

- Sound knowledge of legislative and policy frameworks along with knowledge of the entitlements and rights of the client
- Behave ethically
- Skill engaging clients

6.34 The review found that the advocacy standards developed in 2012 in Northern Ireland, remain relevant today and that the key focus requires to be on the development of outcome measures and evaluation.

6.35 Advocacy skills and competencies

While relevant education and training for advocates is essential, there are no clear standards to define the work or skills required.
In Northern Ireland, Advice NI provides a NI specific level 2 Award/ Independent Advocacy Qualification as an introductory qualification -2-day course accredited by City and Guilds. This course enables candidates to progress to level 4 certificate in

Independent advocacy OCN level 4 certificate in understanding advocacy with 4 mandatory units for a total of 13 credits

6.36 There is a need to address the skills required to advocate on behalf of those with fluctuating or diminished capacity to communicate.

6.37 Advocacy in England, Scotland, Wales and Northern Ireland is shaped by the various country specific legislation and in summary the review found that;

- A regional framework is required in order to create a context within which the practice, skills, development and coordination of advocacy can be effectively realised.
- There is merit in having a regional forum for advocates
- Need for a more integrated approach across programmes of care.

6.38 Key Points

- Training and competencies for advocates needs to be reviewed and standardised and reflected in contract specifications and in monitoring the quality and effectiveness of independent advocacy.
- Personal development for advocates needs to be promoted and standardised
- Induction and orientation training for advocates should be provided by the Trust
- Promoting the full range of advocacy needs to be supported by organisational culture and training for all staff to enable them to accommodate challenge
- The organisational culture required to commission and foster effective challenge by advocates has not been reviewed or tested and will require further consideration.

7.0 Conclusion

7.1 The Belfast Trust requested an independent review of advocacy services as part of the recommendations from both the Margaret Flynn report on Safeguarding and the Leadership and Governance review into Muckamore abbey hospital.

7.2 The review initially focused on the contractual agreement with Belfast Trust and the advocacy provider Bryson House, which is a longstanding contract providing an advocacy service to patients in Muckamore from Belfast and South Eastern HSC Trusts and the regional children's learning disability in-patient unit, Iveagh, alongside a service to adults accessing community learning disability services.

7.3 However, through the process of the review and engagement with key stakeholders, it became clear that the provision of advocacy services to adults with a learning disability was much wider than just the contractual arrangement within Belfast HSC Trust for independent advocacy.

It is very much a regional issue with emerging demands and expectations.

7.4 Previous reviews led by RQIA had made recommendations to look strategically at advocacy services across Northern Ireland but many of these recommendations have not yet been actioned and remain relevant.

7.5 Whilst the contract with Bryson house should be formally reviewed by Belfast Trust, there is a need to consider regionally how best advocacy can be provided to adults and children with learning difficulty across the region.

7.6 The review makes reference to an Advocacy network in Northern Ireland, which had been established in 2014 however, this network no longer exists and one of the recommendations would be to consider the development of such a network to consider regionally how best to meet the needs of service users and to provide a central forum for reviewing and maintaining standards, training and development of advocates.

7.7 The Department of Health, Social Services and Public Safety (DHSSPS) developed principles and standards in 2012 however, there is a lack of regional policy or guidance for advocacy services and the review found that a clear joined up policy direction would help steer this work.

7.8 A regional assessment of need should inform future commissioning, taking account of the broad range of advocacy needs. The review also identified a requirement to develop a clear pathway across the continuum of advocacy options with the principle of independence being paramount.

7.9 There is emerging demand for advocacy services arising from the Mental Capacity Act and the implementation of recommendations from the Hyponatraemia Inquiry and it will be important to understand current and future demand for advocacy across all programmes of care and the interactions between statutory duties.

7.10 Developments in Scotland and England have recognised that integrated advocacy would be of benefit because some people will require more than one type of advocacy.

7.11 There is a lack of meaningful outcomes within the existing contract, detailing how the provision of advocacy has made a difference to the lives of those who have used the service. Measuring the impact of advocacy should be taken forward alongside service users, carers and family members.

7.12 The skillset, training and support networks for those fulfilling the advocacy role needs to be addressed and awareness raised as to the role of advocacy for those who may require independent support.

7.13 The review highlighted that current advocacy arrangements do not have the capacity or capability to meet the demand for advocacy across community learning disability services and that a broad continuum of advocacy to offer choice needs to be developed to include self, group and family advocacy in addition to independent advocacy services.

We would like to extend our thanks to everyone who participated in the review for their time, their support and their honesty. It was much appreciated.

8.0 Recommendations

1. **Consideration should be given to the development of a Regional Policy for Advocacy taking account of the emerging recommendations arising from the workstreams associated with the Hyponatraemia review, the Mental Capacity Act and programme of care specific requirements.**

2. **Consideration should be given to a regional Needs Assessment to determine capacity which enables a regional approach to commissioning advocacy services and should be completed in partnership with all relevant stakeholders to identify gaps in provision**

3. **The review highlighted the importance of Advocacy providers being seen to be fully independent with no conflict of interest. Contract specifications should be reviewed to ensure compliance with this principle**

4. **Consideration should be given to the need for regulation of advocacy services by relevant stakeholders.**

5. **Advocacy support should be available and strengthened at all stages of care planning and automatically offered in all safeguarding investigations**

6. **BHSCT Trust should work with relevant stakeholders to develop and agree Outcome measures to inform Service level agreements which provide assurance on effectiveness and VFM**

7. **A regional forum bringing together advocacy providers should be considered to ensure a regional approach to the continuous review and development of Advocacy standards and agreement on the skill-set, training and professional development for advocates**

8 There are a number of different types of advocacy, for example, citizen, self or group, peer, issue-based and non-instructed advocacy. HSC Trusts should work with Advocacy providers to develop a pathway to reflect the continuum of advocacy options.

9 Peer Advocacy has a strength in ensuring the voice of individuals is heard. BHSCT should engage other HSC Trusts with view to extending Peer advocacy.

10 Guidance should be developed in partnership with those who use services and carers/families to clarify roles and agree referral criteria across the advocacy continuum

11 Turnover of key worker staff has impacted on continuity and the role of this key professional staff member acting as an advocate - BHSCT should include professional advocacy in the continuum of services available and consider the barriers to HSC professionals undertaking this role

12 Consideration should be given to commissioning a child specific advocacy service for young people with a disability who may enter Iveagh and for those receiving learning disability services in the community.

Appendix 1

Independent Review of Advocacy Arrangements in Hospital and Community Learning Disability Services in Belfast HSCT

Terms of Reference

The evaluation of advocacy services relates to the period **1 April 2020 to 30 June 2021** and its starting point is the contractual arrangements which exist with independent advocacy organisations. However, this evaluation should not be limited to the evaluation of advocacy support delivered via Trust contracts, but should take into consideration the extent to which other advocacy arrangements exist and are effective:

- To review the objectives (outputs) of the Trust's advocacy contracts and the annual returns in order to determine whether the objectives have been met
- To determine the number and % of patients and service users in the Trust's learning disability service who avail of commissioned advocacy arrangements
- To determine the number and % of patients in Muckamore Abbey Hospital who have no next of kin, and who have no advocate - and to explore the reasons for this
- To quantify the volume, nature and themes of advocacy support offered patients, service users and carers through this contract (outputs)
- To evaluate the experience of patients, service users and carers of advocacy (outcomes) using the principles set out in the DOH policy guide as a framework. This will include consideration of:
    - Awareness of patients, service users and carers of the existence of advocacy and their understanding of its role
    - The extent to which the existing advocacy arrangements are viewed by patients, service users and carers as sufficiently independent of the Trust to be accepted as a trusted ally
    - The extent to which advocacy support has empowered and enabled patients, service users and carers to influence their care and treatment
    - Where advocacy has not achieved a positive outcome, to explore the reasons for this
    - Impediments which may exist for patients, service users or carers who have expressed a preference for self-advocacy and empowerment

- To evaluate the extent to which Trusts support or hinders effective advocacy. This will include consideration of:
    - What induction and support do Trusts give to new and experienced advocates
    - What opportunities are advocates proactively given by Trusts to come into contact with patients, service users and carers

- How do Trust managers engage and communicate with advocates, how often and in what ways
- How do Trusts promote and encourage advocacy

To make recommendations as follows;

- Areas for improvement on the part of the independent advocacy organisations or on the part of Trusts
- Meaningful outcome measures which should be used by Trusts in commissioning and evaluating its advocacy arrangements on an ongoing basis

Methodology

The methodology adopted for the evaluation should be tailored to the specific stakeholders involved. It is likely that no single methodology will be appropriate. All options should be considered in order to maximise the effectiveness of the evaluation:

- Questionnaires
- Structured Interviews
- Group Discussion
- Review of Contractual Requirements
- Review of Contractual Returns

Stakeholders

The stakeholders who will be involved in this evaluation are as follows:

a. Patients / Service Users
b. Families
c. Advocates
d. MDT staff
e. Commissioning managers

Appendix 2

Independent Review into Advocacy Services at Muckamore Abbey Hospital Questionnaires

Advocate

Independent Review into Advocacy Services at Muckamore Abbey Hospital **Advocate Questionaire**

Question 1: Do you feel supported in your role as advocate?
Answer:
Question 2: Did you have an induction?
Answer:
Question 3: Are you offered opportunities for training and development?
Answer:

Question 4: Do you feel you are making a difference?
Answer:
Question 5: How do you evidence that your making a difference?
Answer:
Further Comments; *Do you have any other comments you wish to make?*

Family/NOK

Independent Review into Advocacy Services at Muckamore Abbey Hospital Family/NOK Questionaire

What is the name of the ward your relative is in ?

Question 1: Have you or your relative ever had an advocate?
Answer:
Question 2: Was this helpful to you or your relative?
Answer:
Question 3: Did you feel your voice was heard?
Answer:

Question 4: Was it easy to get an advocate?
Answer:
Question 5: What might have made this better for you?
Answer:
Further Comments; *Do you have any other comments you wish to make regarding the Advocacy Services at Muckamore Abbey Hospital.*

Service User

Independent Review into Advocacy Services at Muckamore Abbey Hospital Service User Questionaire

What is the name of your ward?

____

Question 1: Have you ever had an advocate?
Answer:
Question 2: Was this helpful to you?
Answer:
Question 3: Did you feel your voice was heard?
Answer:

Question 4: Was it easy to get an advocate?
Answer:
Question 5: What might have made this better for you?
Answer:
Further Comments; *Do you have any other comments you wish to make regarding the Advocacy Services at Muckamore Abbey Hospital.*

Trust Managers

Independent Review into Advocacy Services at Muckamore Abbey Hospital Trust Manager Questionaire

Question 1: What advocacy services are in place across the trust?
Answer:
Question 2: Is this easily accessible?
Answer:
Question 3: How is the advocacy service monitored and reviewed?
Answer:

Question 4: Do you think the advocacy service is making a difference?
Answer:
Question 5: What indicators and measures do you rely on to demonstrate the impact of advocacy?
Answer:
Question 6: How might this service be improved?
Answer:
Further Comments; *Do you have any other comments you wish to make regarding the ? Advocacy Services at Muckamore Abbey Hospital.*

Thank you for taking the time to complete this questionnaire
Please return completed questionnaire by post to:
(Name and Address here and below)
Address
XXXXXX
XXXXX
XXXXX

Or return via email to xxxxxxxxxxxxx

Review of Advocacy in Learning Disability Services 2022

Advocacy Services help people express their views and stand up for their rights. Learning Disability Services in the Belfast Trust are undertaking a review of Advocacy both within the hospital and community settings. The review is being undertaken by two independent consultants, Bria Mongan and Marie Roulston who thank you for the time you are taking to share your experiences in this review.

This survey is anonymous unless you wish to provide your contact details. All your answers will kept confidential, however, we may wish to use anonymous quotes in reports resulting from the questionnaire. If you do not wish your comments to be included, please indicate this in Question 7.

1. **Have you used advocacy services?**

   Yes ◯

   No ◯

2. **What was the name of the advocacy service that supported you?**

   Bryson House ◯

   Patient Client Council (PCC) ◯

   VOYPIC (Iveagh – Children's service) ◯

   Mencap (MAH only) ◯

   Disability Action (MAH only) ◯

   Other (please name service in Q7) ◯

3. **Do you feel advocacy services are easily accessible to you?**

   Yes ◯

   No ◯

4. **Do you feel advocacy services are helpful?**

   Yes ◯

   No ◯

5. If you have acted as an advocate for your loved one, do you feel your voice was heard?

Yes ◯

No ◯

6. What might have made the experience better?

7. Please share any other comments that you wish to be considered in the review of advocacy services.

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 2 September 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Brenda Creaney	Belfast Trust
Charlotte McArdle	DoH (Joint Chair)	Gillian Traub	Belfast Trust
Maire Redmond	DoH	Bernie Owens	Belfast Trust
Mark Lee	DoH	NI British Psychological Society representative	
Ian McMaster	DoH		
Aine Morrison	DoH		
Siobhan Rogan	DoH		
Sean Scullion	DoH (Note)		
Marie Roulston	HSCB		
Briege Quinn	PHA		
Rodney Morton	PHA		
Dawn Jones	Family representative		
Brigene McNeilly	Family representative		
Aidan McCarry	Family representative		
Margaret O'Kane	South Eastern Trust		
Tracy Kennedy	Belfast Trust		
Patricia McKinney	Belfast Trust		
Karen O'Brien	Western Trust		
Petra Corr	Northern Trust		
Barney McNeaney	Southern Trust		
Stephen Matthews	Cedar		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Tony Stevens	RQIA (observer)		
Lynn Long	RQIA (observer)		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees and noted apologies received. He advised members that the meeting was again being held by video-conference in light of

the continuing Government guidance on social distancing, and this arrangement would be kept under review for future meetings.

2. He advised members that Margaret Kelly had left the Group to take up a new post, and extended his appreciation to her for her contribution to the work of MDAG. A replacement for her on MDAG would be identified as soon as possible.

3. He also advised the Group that David Bingham, the Chair of the independent panel who carried out the Leadership and Governance review into the hospital would join the meeting to brief members on the Review's findings.

Agenda Item 2 - Minutes of Previous Meeting

4. The minutes of the previous meeting held on 24 June were agreed by members, subject to amendment of the wording on two specific points highlighted by members.

5. Sean Holland noted that the summary of the key points from the 24 June meeting which had been circulated to members following the meeting had subsequently been reported on in the media. As there is a risk that some of the information contained in MDAG minutes may have the potential to enable the identification of individual hospital in-patients with attendant implications for their confidentiality, he proposed that in future full MDAG minutes should be produced immediately following meetings and published on the Department's website once agreed by MDAG members. The Group indicated their agreement to this.

Agenda Item 3 – Update on Action Points.

6. Sean Holland provided an update on the open action points arising from previous meetings. He advised that the Belfast Trust will provide an update on their engagement with the East London Foundation Trust at the next scheduled MDAG meeting. He noted that the Department had arranged a meeting with the HSCB to agree the way forward for the resettlement programme, and advised

that members would be provided with an update on this at the next MDAG meeting.

7. He noted the report on the evidence for the effectiveness of CCTV in care homes had been circulated to members and updated members on the Belfast Trust's contact with the relatives of patients involved in the Ennis report. He asked that the Belfast Trust update the group of the listening event planned for families following publication of the Leadership and Governance Review be brought to the next MDAG meeting. He further asked that an update as to progress of the Regional Contingency Plan also be brought to the next meeting.

Agenda Item 5 - Implementation of Leadership and Governance Review recommendations

8. Seán Holland provided a summary of the recommendations from the Review report and members agreed that these are monitored through MDAG by adding to the current HSC action plan.

Agenda Item 6 – Update on MAH staffing position

9. The Chair asked for an update on this agenda item pending David Bingham joining the meeting. Patricia McKinney advised that as of 31st August 2020 there are 30.82 whole time equivalent registered Learning Disability nurses (Band 5-7 inclusive) and 100.08 whole time equivalent Nursing assistant (Band 3) substantive staff in MAH (inclusive of Maternity leave and Sick leave).

10. The Trust have secured a 12 month commitment from the agency who provides the largest number of registrants on site for 50 whole time equivalent registrants, and have worked with the Belfast Trust nurse bank to secure this commitment which will help to maintain and sustain services over the Winter and into next year.

11. Recruitment is continuing with eight band 5 registrant posts offered in recent recruitment exercises. Four staff have started and a further one will start in early September.

12. Patricia also updated members on arrangements instigated by the Nursing and Midwifery Council (NMC) to support the pandemic response which allowed nursing students to opt in to join the workforce in a paid capacity for their final 6 months, whilst still retaining their student status. The Department of Health issued guidance to employers that students who opted in to the paid arrangements should be remunerated at Band 4 (AfC). They were also supported in their learning during this time. The feedback from the students was very positive. It was also clear from feedback from the teams that these students were very valued by them. There were 7 transition students in MAH. Four of the students were subsequently offered posts in the hospital and are included in the numbers above.

Agenda Item 4 – Leadership and Governance Review briefing

13. David Bingham joined the meeting to provide members with a briefing on the report of the Leadership and Governance review. He summarised the methodology the panel used in their review and also the key findings, which were that vulnerable patients and their families were failed by the hospital which operated as a place apart out of the line of sight of the Trust, the Muckamore hospital management team was dysfunctional, the Ennis report was a missed opportunity to identify institutional abuse, Trust governance arrangements were ineffective and advocacy arrangements lacked independence.

14. Sean Holland welcomed the briefing and invited members to raise any questions.

15. Family representatives indicated they had found reading the report to be very distressing and expressed concern that senior Trust staff were not being held to account for the failings identified. They considered that the findings were further evidence that people with learning disabilities were not regarded as a priority by health and social care services. One of the family representatives asked Group members for their views on the report's findings.

16. Sean Holland advised he was ashamed to be associated with what had happened at the hospital, and stressed the need for real changes to address these issues. He noted in particular the findings in relation to shortcomings in adult safeguarding arrangements and also referenced similar findings emerging from reports on Dunmurry Manor.

17. Charlotte McArdle acknowledged the report made difficult reading, and felt the same feelings of shame, devastation and anger described by Sean Holland. Charlotte commented that with hindsight of course things could have been different and committed to learning the lessons and making necessary changes. Charlotte said as a mother and sister it was by luck that she was not standing in the relatives' shoes of people in Muckamore Abbey Hospital. She also stressed the importance of addressing perceptions that people with learning disabilities were viewed as a lower priority for HSC services.

18. Another family representative expressed frustration with difficulties in making contact with senior Trust staff which contributed to a breakdown in trust between families and hospital staff. Concerns were also expressed that incidents were continuing to occur at the hospital, and that families were not being involved in planning for the future direction of the hospital.

19. Sean Holland noted the concerns raised, and indicated he would be willing to discuss these further with family representatives in a separate meeting.

AP1: Meeting to be arranged between Sean Holland, HSCB and MDAG family representatives (Action: DoH).

20. Marie Roulston on behalf of the Health and Social Care Board expressed empathy with families on the content of the report, and advised she had shared with Trust Directors of Social Work to ensure the lessons it contained on working with vulnerable adults were disseminated across all services. She reiterated the commitment of the HSCB to work with the Department and Trusts to ensure all necessary changes were implemented.

21. Rodney Morton acknowledged the report was painful for families and that it indicated nurses had let patients down, and extended an apology for that. He

stressed the importance of independence in delivering effective advocacy, and asked whether the panel had identified any measures which might strengthen this.

22. David Bingham advised that the panel had found that advocacy arrangements in place at the hospital had been directed primarily towards facilitating resettlement, and suggested contracts between the Trust and advocacy organisations be reviewed to ensure conflicts of interest are avoided.

23. Family representatives indicated they had raised this issue repeatedly with the Trust and the HSCB without success, and suggested that each patient should have an independent advocate.

24. Tracy Kennedy advised that the report's content had been shared with all staff on site through a number of briefing sessions, and that all staff had been directed to the full report published on the Department's website. A summary had also been circulated to staff who were not at work. She expressed an apology for past failings at the hospital, and advised that the Trust were working to ensure there would be no recurrence of these across the Trust's Learning Disability services.

25. Sean Holland advised members that the Minister was considering the review's findings, and had signalled his intention to meet again with patient's families. Arrangements for this were being made.

26. The family representatives asked whether a decision had been made on a public inquiry, and Sean Holland advised that the Minister wished to consult further with families on the appropriate form of inquiry.

27. The family representatives asked about arrangements for family and carer involvement in planning decisions and advised that many families and carers had become disillusioned with arrangements to engage with them, pointing to limited family involvement on the Trust Carer's Forum as evidence of this.

28. Vivian McConvey acknowledged the difficulties, and suggested that a one-to-one approach tailored to individual's wishes might help to deliver improved

levels of engagement. She advised she would dedicate a member of the Patient Client Council staff to this work with the aim of working with families to develop a plan for effective advocacy arrangements at the hospital. The family representatives indicated they would be willing to support this approach, and Vivian advised she would implement this through contact with the MDAG family representatives initially.

AP2: Contact MDAG family representatives to agree implementation of plan to improve advocacy arrangements at the hospital (PCC)

29. Tracy Kennedy advised the hospital team on site were willing to engage with families and carers in whichever forum was preferred by families and carers.

30. Marie Roulston stressed the importance of effective engagement arrangements being in place across all Learning Disability services, including services for children with disabilities, and Siobhan Rogan made the point that any such arrangements must also make provision to facilitate input from patients.

31. David Bingham advised that the panel had queried whether the current ownership of Muckamore Abbey Hospital by the Belfast Trust was the optimal arrangement, and also whether the predominantly medical model of services in place at the hospital was the appropriate one in the future.

32. Sean Holland thanked David Bingham for his briefing and for the work carried out by the independent panel. He indicated that the remaining items on the meeting agenda would be carried forward for consideration at the next MDAG meeting, which will be held on 28th October.

Summary of Action Points

Ref.	Action	Respon -sible	Update	Open/ closed
2/09/AP1	Meeting to be arranged between Sean Holland,	DoH		

	HSCB and MDAG family representatives			
2/09/AP2	Contact MDAG family representatives to agree implementation of plan to improve advocacy arrangements at the hospital	PCC		

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Muckamore Departmental Assurance Group (MDAG) April 2021

MAH HSC Action Plan Report

Ref: MDAG 06/2021

Introduction

1. This report provides an update on progress on the MAH HSC Action Plan, and summarises the key changes to the Action Plan since the previous update provided for the MDAG meeting on 24 February.

April update

2. Action owners were asked to provide updates on those actions for which they are responsible. The updates they provided are included in the table attached at Annex A.

3. Two actions which were rated green in the February update (**A47** and **A48**) have now been moved to Section A, the completed actions section.

4. A further three actions (**A3**, **A10** and **A22**) have been reported by their action owners as completed, and the ratings for these actions have accordingly been upgraded to green.

5. Four actions (**A8**, **A12**, **A34** and **A40**) have now moved beyond their target dates, and the ratings for these actions have accordingly been updated to red.

6. A summary of the current status of the revised actions in the Plan is set out in the table below, including the change in each from the February update report.

Summary of Progress against Targets – April 2021

			TOTAL
15(+3)	18(-6)	21(+3)	54

RED - Progress required AMBER – Work in progress GREEN – Completed

Actions rated red

7. Of the 15 red rated actions, 3 (**A1**, **A2** and **A7**) relate to resettlement. As previously noted (MDAG/02/21), while work is continuing to progress the resettlement programme, the pace of the resettlement programme has been impacted by the Covid pandemic. The placing Trusts have been asked to provide MDAG with an update on their plans for each of their current in-patient populations, and this has been tabled separately for consideration by MDAG (paper MDAG/07/21 refers).

8. There remains one red target under the workforce theme (**A29**), and an update on work to progress this is included in Annex A.

9. The transformation theme has four red rated targets, an increase of one from the February update. **A40** (which is linked to **A39)** has also been moved to red, with both actions delayed pending identification of required funding. **A21** which had a target date of January 2021 remains red pending completion of the Belfast Trust's review of their seclusion policy. **A8** had a target date of March 2021 and thus moves to red, with work continuing on a regional procurement model.

10. However **A10** which relates to the review of LD forensic services and was previously rated red has been moved to green following completion of the review.

11. There are now three red rated targets in the Children and Young People theme, with **A12** which had a target date of March 2021 moving from amber to red, along with the previously red rated actions **A13** and **A14.** Updates on progress towards implementing these three actions are included in Annex A.

12. The two previously reported red targets under the governance theme, **A25** and **A26** remain red, and an update on the work being taken forward by the Belfast Trust in relation to both of these is provided at Annex A. In addition, **A34** which has been delayed due to changes at Director level in the HSCB moves to red, though the expectation is that this action will be expedited shortly.

13. Under the safeguarding theme**, A23** remains red, and this action is being progressed in the context of the wider regional programme of work on safeguarding arrangements.

Risk Register

14. To support MDAG in the discharge of its Terms of Reference, specifically to provide the DoH and thus Minister with a clear line of sight on progress towards delivering the commitments set out in the MAH HSC Action Plan, and also provide a forum for the escalation of issues and risks from the Mental Health and Learning Disability Improvement Board, we are proposing to develop an Action Plan risk register.

15. The risk register would identify and document the potential risks to delivery of the actions set out in the Action Plan, and provide MDAG with the opportunity to consider and manage these effectively with a view to mitigating any adverse impacts on the delivery of the Plan.

16. If members are content to agree this proposal, a draft Risk Register can be tabled for consideration at the June MDAG meeting.

Summary

17. MDAG members are asked to:

    i) Note and agree that actions **A3, A10** and **A22** are recorded as completed:
    ii) Note the updates on the 15 actions in the plan which are rated red; and
    iii) Note and agree that a draft risk register for the MAH Action Plan be developed and tabled for consideration at the June MDAG meeting.

MDAG/06/21

ANNEX A

MUCKAMORE ABBEY HOSPITAL HSC ACTION PLAN

April 2021

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the Health and Social Care Board.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice across the full spectrum of learning disability services in Northern Ireland.

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

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LEADERSHIP AND GOVERANCE REVIEW RECOMMENDATIONS	SECTION H	

RAG Rating	
Completed	(green)
Work in progress	(amber)
Progress required	(red)

SECTION A

COMPLETED ACTIONS

Permanent Secretary commitments						
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**DOH**	**A4**	By 31 **August 2019**, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming Minister) that the resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at **Annex A**).	**Governance**	
PS1		**DoH/DoJ**	**A9**	By **31 December 2019,** provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	**Governance**	
SAI Independent Review Panel recommendations						
R1.	Evidence of a renewed commitment (i) to	**HSCB/PHA**	**A11**	By **December 2020,** deliver a co-produced model for Learning	**Service Model**	

R.2	enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course. An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local			Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation. **Postscript-April 2021** We Matter' Learning Disability Service Model, a High Level Consultation Summary, live Strategic Delivery Plan and an Equality Screening (which is currently under way) will be submitted to DoH on 14th May.		

	services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.					
	Long term partnerships with visionary housing associations, including those with experience of developing shared	**HSCB/HSC Trusts**	**A15**	By **30 June 2020** review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.	**Accommodation**	

	ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.					
		HSCTS	**A16**	By **31 December 2019** address security of tenure of people with a learning disability living in supported housing.	**Accommodation**	
		HSCTs	**A17**	By **31 March 2020** complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to	**Accommodation**	

				inform future funding decisions for adult LD.		
SAI Patients families recommendations						
R4.	Families and advocates should be allowed open access to wards and living areas.	**Belfast, Southern and Western Trusts.**	**A19**	Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey).	**Service Model** **(Assessment & Treatment)**	
R5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	**Belfast, Southern and Western Trusts.**	**A20**	By **30 June 2020,** carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	**Service Model** **(Assessment & Treatment)**	
R8.	People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support	**Belfast Trust**	**A24**	By **31 December 2019,** review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved, taking account of lessons emerging from	**Service Model**	

	services for their relatives.			Independent Review into Dunmurry Manor.		
R11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	**Belfast Trust**	**A27**	By **31 October 2019,** provide an information booklet to families on the complaints process.	**Governance**	
R12.	Families receive regular progress updates about what is happening as a result of the review.	**Belfast Trust**	**A28**	By **31 October 2019,** a schedule of Trust meetings with families will be produced and circulated to families.	**Governance**	
SAI Senior Trust staff recommendations						
R16.	A shared narrative is set out.	**HSCB/ PHA/HSC Trusts**	**A33**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.	**Service Model**	

R18.	The transformation required in learning disability services must be values driven and well led.	**HSCB/ PHA/HSC Trusts**	**A35**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.	**Service Model**	
R19.	The purpose of all our services is clear.	**HSCB/ PHA/HSC Trusts**	**A36**	By **December 2020,** the LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	**Service Model**	
R23.	Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	**HSCB/ PHA/HSC Trusts**	**A42**	By **December 2020** the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are	**Service Model**	

				in place on an ongoing basis to fully operationalise this commitment.		
R24.	Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.	**DoH/HSCB/ PHA/HSC Trusts**	**A43**	By **December 2020,** all parts of the HSC will have been involved in the development of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.	**Service Model**	
LG4	The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.	**HSCB/PHA**	**A47**	This was taken to HSCB/PHA Quality, Safety and Experience meeting on 3/2/21.QSE were asked to discuss potential mechanism to seek Trust assurances. It was agreed that this will be listed for discussion at the quality, safety and experience meeting with Trusts.		
LG5	Pending the review of the	**HSCB/PHA**	**A48**	This work has been actioned by HSCB and is progressing and is		

	Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.			being led by the Governance Lead in HSCB.		

SECTION B

RESETTLEMENT

Permanent Secretary commitments						
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**HSC Trusts**	**A1**	By **30 November 2019** carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to discharge. **April 2021 update** The Mallusk development is completed, however significant challenges remain around care	**Resettlement**	

				staff recruitment. Individual placements continue to be progressed. Each Trust provides regular updates on discharge planning. A summary of the current Resettlement status of the remaining MAH in-patients, including indicative timescales, has been collated by each Trust for presentation to MDAG (paper MDAG/07/21 refers).		
PS1		**HSCB/HSC Trusts**	**A2**	By **30 November 2019** develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge. **Linked to A1.** **April 2021 update** Please refer to above response to A1.	**Resettlement**	

				The Regional Learning Disability Operational Delivery Group (RLDODG) continues to meet to consider obstacles to resettlement. The dash board provides the updated situation, and a summary of the current Resettlement status of the remaining MAH in-patients, including indicative timescales, has been collated by each Trust for presentation to MDAG (paper MDAG/07/21 refers).		
noPS1		**DoH/HSCB/HSC Trusts**	**A7**	By **30 September 2020,** in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability. **April 2021 update**	**Resettlement**	

				Trusts continue work to scope potential new developments and attract new independent sector providers. The RLDODG continues to meet on a monthly basis to progress solutions. This is complemented by the work completed in the Regional Housing Needs assessment and a Regional Procurement task and finish Group to procure enhanced domiciliary care services for those with complex needs. This work is ongoing and will be until resettlement is completed.		

SECTION C

WORKFORCE

Permanent Secretary commitments						
PS1		**DOH/HSCB/HSC Trusts**	**A5**	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care e.g. Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff. **April 2021 update** Trusts continue to work with HSCB to develop enhanced services and care pathways in the community via the Community Assessment and Treatment Pathway Group. Significant investment is	**Workforce**	

				required to implement a Positive Behaviour Support model regionally. An initial draft and subsequent redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs approach have been shared with the Task and Finish Group. A further meeting was scheduled for 16th April to discuss comments on the draft.		
SAI Hospital Staff Recommendations						
R13.	An enhanced role for specialist nursing staff is set out.	**Belfast Trust**	**A29**	By **30 June 2020,** develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work. **April 2021 update** The expert reference group (ERG) have been in the process of agreeing proposed nurse staffing ratios for learning disability inpatient services across the region, developed based on a review of the	**Workforce**	

				available evidence and in partnership with existing services. Work is now underway to verify the Telford information submitted to the ERG by Trust workforce leads. The Divisional Nurse continues to support this work.		
		DOH	**A30**	By **June 2021,** complete a review of Learning Disability Nursing. **April 2021 update** The review is progressing with stakeholder engagement events scheduled up until early June. The review is still expected to be completed by end of June 2021 however this date could potentially be impacted due to an unexpected change in the review team.	**Workforce**	
R20.	All Trusts should invest in people-skills and be cautious about focusing	**DoH**	**A37**	By **September 2021,** develop an evidence based plan for recruitment, training and retention of a sufficiently skilled	**Workforce**	

	solely on learning disability nursing.			multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services. **April 2021 update** In the context of the completed LDSM, work is continuing to establish by September 2021 a working group with an agreed ToR to progress the development of an evidence based workforce plan for LD services.		

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SECTION D

TRANSFORMATION: [SERVICE MODEL; ACUTE CARE REVIEW; ASSESSMENT & TREATMENT]

Permanent Secretary commitments						
PS1		HSCB / PHA	A3	By **March 2021**, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes. April 2021 update An initial draft and subsequent redraft of the Community Based Assessment and Treatment (CAT) for People with a Learning Disability and Complex	**Acute Care Review**	Rating changed from amber to green

				Needs approach have been shared with the Task and Finish Group. A further meeting was scheduled for 16th April to discuss comments on the draft.		
PS1		**HSCB/PHA**	**A6**	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent review of acute inpatient care. **April 2021 update** An initial Draft and subsequent redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs approach have been shared with the Task and Finish Group. A further meeting was scheduled for 16th April to discuss comments on the draft.	**Assessment & Treatment**	

PS1		HSCB/HSC Trusts	A8	By **March 2021,** in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff. **April 2021 update** No further update. Trusts continue to work with HSCB and Social Care Procurement Unit to develop a regional procurement model.	**Service Model**	Rating changed from amber to red
PS1		**HSCB/HSC Trusts**	**A10**	By **30 December 2020**, review current forensic LD services, identify and address service development needs to support people in community settings. **April 2021 update** Trusts continue to engage in development of draft paper on forensic services, which is led by HSCB. This paper has been shared with DOH and comments	**Service Model**	Rating changed from red to green

				received. Revisions to be made to the paper and the work to be factored into other strategic pieces of work which are ongoing. Rating should change to green as review is completed.		
SAI Patients families recommendations						
R6.	The use of seclusion ceases.	**Belfast, Southern and Western Trusts.**	**A21**	By **31 January 2021,** complete an urgent review of seclusion policy and practice in MAH (and Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families. **April 2021 update** Belfast Trust has completed a review of the seclusion policy and has sought DLS advice re the status of voluntary patients and the legislation around the particular forms that might be required. This was due to be signed of through Trust processes by January 2021. Policy proceeded through Trust Processes, but was returned by	**Service Model** **(Assessment & Treatment)**	

				Equality Team with some suggested amendments prior to final adoption and these are now under review. Southern Trust review of seclusion policy completed. Western Trust do not currently use seclusion in their in-patient facility.		
SAI Senior Trust staff recommendations						
		HSCB/ PHA/HSC Trusts	**A38**	By **March 2022,** deliver community and home treatment services support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary. **April 2021 update** An initial draft and subsequent redraft of the Community Based	**Service Model** **(Assessment & Treatment)**	

				Assessment and Treatment (CAT) for People with a Learning Disability and Complex Needs approach have been shared with the Task and Finish Group. A further meeting was scheduled for 16th April to discuss comments on the draft.		
R21. **R22.**	The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop. Time limited and timely Assessment and Treatment become the norm.	**HSCB/PHA/ HSC Trusts**	**A39**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services **April 2021 update** No further update to February submission. Previous funding was non-recurrent, ending March 2020. Recurrent funding is required to recruit to this post.	**Service Model** **(Assessment & Treatment)**	
		HSCB/HSC Trusts	**A40**	By **30 November** 2019, appoint a regional bed manager for all 3 current in-patient units. **April 2021 update**	**Service Model** **(Assessment & Treatment)**	Rating changed from amber to red

				Please refer to response in A39. No further update is available from HSCB.		
		HSCB/PHA/ HSC Trusts	**A41**	By **March 2022,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge from hospital. (See Permanent Secretary commitments). **April 2021 update** Awaiting sign-off of regional LD model. An initial draft and subsequent redraft of the Community Based Assessment	**Service Model** **(Assessment & Treatment)**	

				and Treatment (CAT) for People with a learning disability and Complex Needs approach have been shared with the Task and Finish Group. A further meeting was scheduled for 16th April to discuss comments on the draft.		

SECTION E

CHILDREN AND YOUNG PEOPLE

SAI Hospital Staff Recommendations						
		HSCB/PHA/ HSC Trusts	**A12**	By **March 2021** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care needs.	**Children and Young People**	Rating changed from amber to red

				• People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours. **April 2021 update** Trusts each have a transition pathway from children to adult services and will review harmonisation of pathways as part of the implementation of the regional review of learning disability services. This work is shared across education and Health and Social Care. The DoH, HSCB and QUB have worked to develop a specialist assessment tool for Children with Disabilities, including those with a Learning Disability, under the Building Better Futures for Families Assessment Framework. This assessment model was launched by DoH on 11 March 2021.		

		HSCB/PHA/ HSC Trusts	**A13**	By **31 December 2020** finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood. **April 2021 update** This is being finalised. Specific bids were developed to support this work as part of the proposed 3 year spending programme. As 2021/22 is to be a one year budget it is unclear at this stage that these proposals will progress in 2020/21.	**Children and Young People**	
		HSCB/PHA/ HSC Trusts	**A14**	By **31 December 2020** review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should	**Children and Young People**	

				be developed locally to meet their needs. This should be aligned to the ongoing regional review of children's residential services. **April 2021 update** The DoH, HSCB and QUB have worked to develop a specialist assessment tool for Children with Disabilities, including those with a Learning Disability, under the Building Better Futures for Families Assessment Framework. This assessment model was launched by DoH on 11 March 2021.		

SECTION F

GOVERNANCE

SAI Patients Families Recommendations						
R3	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	**Belfast Trust**	**A18**	Appoint a carers consultant and co-produce a communications strategy with parents and carers. **Completed** **April 2021 update** This post was re-advertised in March 2021. Shortlisting is currently being completed. Interview dates are being arranged for May.		
R6.	The use of seclusion ceases.	**DOH**	**A22**	By **March 2021,** develop a co-produced and publish regional seclusion and restraint policy/guidance. **April 2021 update** A draft policy document was delivered on 31 March 2021, which will undergo normal approval processes.	**Governance** **(Mental Health Action Plan)**	Rating moved from amber to green

R9.	The Hospital's CCTV recordings are retained for at least 12 months.	**Belfast Trust**	**A25**	By **31 October 2019,** liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation. **April 2021 update** Estates department facilitating specification and further capital requirements to complete a full replacement.	**Governance**	
R10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	**Belfast Trust**	**A26**	By **30 November 2019** develop an information paper and share with families and staff. April 2021 update This requires a regional approach. The Trust is developing a leaflet that will provide more guidance to families as regards escalation of concerns both within and external to the MAH site.	**Governance**	

R17.	Commissioners specify what "collective commissioning" means.	HSCB	A34	By **March 2021,** HSCB to write to BHSCT outlining the current position and status of commissioning for HSC Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor. **April 2021 update** Due to changes at Director level in HSCB, this letter was not issued in March 2021 as planned. It will be actioned by the new director expediently.	**Governance**	Rating moved from amber to red

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SECTION G

SAFEGUARDING

SAI Patients families recommendations						
R7. **R.14**	The perception that people with learning disabilities are unreliable witnesses has to change. Responses to safeguarding incidents and allegations are proportionate and timely.	**Belfast Trust**	**A23/A31**	By **30 June 2020,** complete a review of Adult Safeguarding culture and practices at MAH, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **April 2021 update** The Trust's overarching group which looked at the recommendations in relation to Dunmurry Manor was stood down as a result of Covid-19. The second surge of COVID 19 has further delayed this. CPEA recommendations included a major adult	**Safeguarding**	

				protection change programme in N. Ireland and consideration of an Adult Protection Bill. This work, in the first instance, is being led by the DoH with the introduction of a new Adult Protection structure in N Ireland. The Transformation Board, chaired by the Chief Social Work Officer, has been established and BHSCT are represented on this Board. The interim Adult Protection Board is due to be established and the BHSCT will be guided by the Transformation Board and the interim Adult Protection Board regarding the priority actions to be taken forward. DoH produced a draft ASP Bill on 17 December 2020 and consultation on this closed on 11 March 2021.		
		HSCB	**A32**	By **December 2021,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration	**Safeguarding**	

				of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **April 2021 update** The first meeting of the Interim Adult Protection Board took place in February 2021. As part of the Board's draft work plan, actions have been agreed around a review of Joint Protocol arrangements and separately, work that will inform decisions about revised and simplified Safeguarding documentation.		

SECTION H

Leadership And Governance Review Recommendations						
LG1	The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.	**DOH**	**A44**	By March 2022, complete a review of the accountability arrangements for DSF. The HSCB are developing an outcomes based reporting template which will be the first stage of this process. In preparation for the Social Care Directorate moving into the Department following the closure of the HSCB in 2022, a review of the accountability arrangements for DSF will be undertaken.		
LG2	The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and	**DOH**	**A45**	The Department has carried out a fundamental review of the 2003 Order and the existing regulatory framework and has developed a new draft regulatory policy that includes the principles of regulation, along with the broad scope of services to be regulated and the		

	inspecting all hospital provision.			proposal that the regulator should have wider powers of enforcement etc. This work has been the first phase of the process and we intend to consult on the draft policy before moving on to phase 2, which will include the risk assessment of each provider type and consider the appropriate regulatory approach, including the range of enforcement and sanctions. Phase 2 will result in a clear regulatory framework and legislation and this framework will reflect Departmental Policy. A Departmental Reference group was established to enable relevant policy areas to be involved in the development of the draft regulatory policy in Phase 1 and to shape the regulatory framework in Phase 2. Minister approved the draft policy for consultation earlier this		

				year but the impact of Covid-19 and the subsequent refocus of Departmental priorities has meant that this work was paused in October, before the consultation was launched.		
LG3	The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.	**DOH**	**A46**	By June 2021, develop in partnership with patients, relatives and carers a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site, including appropriate management arrangements.		
LG6	Specific care sensitive indicators should be	**HSCB/PHA**	**A49**	**April 2021 update** This work is being led through the LD mental health and		

	developed for inpatient learning disability services and community care environments.			wellbeing improvement group. A scoping exercise has been carried out across the 5 Trusts by LD Nurse leads. An action plan to agree consistent Key Performance Indicators based on the findings will be agreed following a meeting on 22nd April 2021 with the Deputy Chief Nursing Officer.		
LG7	The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.	**Belfast Trust**	**A50**	By January 2021, complete disciplinary action in respect of first 7 individuals whose cases have been forwarded by PSNI to PPS. Action against a further 9 individuals will commence when PSNI confirm their cases have been forwarded to PPS. **April 2021 update** The Trust continue to progress Disciplinary action in line with employment law regulations. The PPS released a statement on 16 April 2021 indicating that the first file of 7 individuals is proceeding to prosecution, and that a second file remains under consideration.		

LG8	The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.	**Belfast Trust**	**A51**	A Co-Director for Learning Disability services was appointed in June 2020. The dedicated Divisional Nurse post remains and a dedicated Service Manager and two permanent dedicated Assistant Service Managers for the hospital have been appointed. Substantive appointments at Band 7 and Band 6 Ward Manager and Deputy Ward Manager level are being progressed. The Interim Director for Learning Disability Services will review the existing managerial arrangements as part of the Chief Executive's overall review of Directorate and Divisional structures which will take place in 2021.		
LG9	Advocacy services at MAH should be reviewed and developed to ensure they are capable of	**Belfast Trust**	**A52**	By March 2021, complete a review of advocacy services. The Trust is engaging with representatives of Families Involved Northern Ireland (FINI) to develop Terms of Reference		

	providing a robust challenge function for all patients and support for their relatives and/or carers.			for a review of its advocacy arrangements. **April 2021 update** Meetings have now taken place with representatives from Families Involved NI to develop Terms of Reference for a review of advocacy services. A final draft is now available and will be shared with HSCB and other Trusts in April 2021.		
LG10	The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.	**Belfast Trust**	**A53**	The Trust have engaged with Mr B and written to him in an attempt to address his outstanding concerns. The resolution of these concerns is ongoing at this time and while every effort will be made to progress the investigation into the outstanding issues of concern, it is not at this stage possible to provide a definitive completion date. **April 2021 update** No further update at this point.		

LG11	In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.	**Belfast Trust**	**A54**	CCTV is currently used to inform and amend staff practice. Contemporaneous CCTV footage is independently viewed and the accounts of this footage, which reflects good practice and highlights any areas for concern, are shared with staff. Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site. These questionnaires specifically asked for views on the proposed extension of the use of CCTV into areas such as training and practice development. Feedback from the questionnaires will inform next steps. **April 2021 update** No further update at this point.		
LG12	The size and scale of the	**Belfast Trust**	**A55**	The Trust Chief Executive is		

	Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.			responsible for holding Trust Directors to account for achievement against their objectives, which are set on an annual basis and reviewed monthly (these are modified as issues arise). Directorate and Divisional management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a developing quality management system (QMS) which will provide a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system will facilitate the Trust Board to provide ongoing challenge throughout the year, rather than being responsive to issues escalated to it.		

1.007

MDAG/08/2021

Muckamore Departmental Assurance Group (MDAG) February 2021

Highlight Report

Ref: MDAG – 08/21

MDAG Highlight Report	
MDAG Objectives	i. The services being delivered at Muckamore continue to be safe, effective and fully Human Rights compliant; ii. The commitment given by the Permanent Secretary to resettle patients is met, and the issue of delayed discharges is addressed; iii. The team on site at Muckamore is given the support and resources necessary to achieve their goals; and iv. The lessons learned from Muckamore (including the Serious Adverse Incident report) are put into practice consistently on a regional basis in line with wider policy on services for people with learning disabilities, and also inform the work underway to transform Learning Disability services in each Trust.

Update
<u>**Safeguarding/Police Investigation**</u> • The current MAH Adult Safeguarding (ASG) team consists of a Service Manager, 1.8 whole time equivalent Band 8As, 4 Band 7 CCTV viewers, 1 MAPA (Management of Actual and Potential Aggression) viewer, 1.2 whole time equivalent Family Liaison Officer social workers, plus 1 Data Analyst and 1 Administration Officer. • The focus of the work continues to be as follows: - Viewing raw footage already viewed by the PSNI to identify incidents of concern, where appropriate. Initiate referrals to senior management for interim protection plans and where appropriate refer to PSNI; - Viewing the additional PICU incidents previously identified by PSNI but not yet viewed by the MAH historic ASG team; - Quality assure the database and to merge work of the initial Adult Safeguarding team with the work of the current Adult Safeguarding team, to ensure that there is one database which holds all relevant information;

- Notify and support affected families where incidents of concern are identified. This includes cross-Trust liaison work;
- Support affected families when additional information in respect of the MAH, including the PSNI investigation is placed in the Public domain; and
- Provide information when requested by the external disciplinary investigators or the PSNI in respect of their criminal proceedings.

- From a safeguarding perspective it is positive to note that at this stage all raw CCTV footage relating to the timeframe of the historical investigation has been viewed by either the Trust or the Police. The MAH Adult Safeguarding team have completed viewing of raw footage from Cranfield Wards 1 & 2. Police have completed viewing of PICU, Six Mile Assessment and Treatment Wards. Therefore, collectively all raw CCTV footage has been viewed by either Police or Trust.

- The MAH Historic Adult Safeguarding team is also now viewing the additional PICU incidents identified by police. It is important to note that these incidents were previously shared with senior management / HR for protection planning but still required processing via the MAH Adult Safeguarding team and a review of the protection planning process by the Designated Adult Protection Officer (DAPO).

- There is significant work underway in relation to quality assuring the adult safeguarding database and through this process there have been a number of staff identified where it has been difficult to confirm their identity. From a safeguarding perspective, the MAH Adult Safeguarding team have been undertaking work to establish the identity of these staff and good progress has been made. In addition, all patients have now been identified from footage viewed.

- In addition to the above, the Team provide a Family liaison support role to the families whose loved ones have been identified through the investigation. Since the last report the PPS's decision to commence criminal proceedings in relation to seven staff was made public. This required the team to respond on the same day to provide support to all of the families known to the Team.

- Whilst families are relieved to hear that the PSNI investigation is progressing, those who did not receive written communication from the PPS continue to voice their concerns that they are hearing this information for the first time when it is in the public domain rather than in advance. When this happens, it reinforces for these families their deep sense of hurt and anger.

Family Liaison

- In the period between 6th February 2021 and 9th April 2021, the following Family Liaison work has taken place:

Home visits	0
Telephone calls	714
Emails	624
Text messages	194
Video conferencing	63

Operational Group meetings

- The Operational Group comprising of representatives from ASGMAH team, HR/Management, RQIA and the PSNI continue to take place every three weeks to review the management decisions in relation to the safeguarding referrals made. Additional meetings have been established over the past two months to consider the protection plans that are being reviewed.

Strategic Governance Meetings

- The Safeguarding Governance Group comprising of senior representatives from the Trust, PSNI, RQIA, HSCB and DoH met on 18th March 2021. It has been agreed that these meetings will now occur every two months with the next meeting taking place on 20th May 2021. The role of this group is to provide oversight and governance in relation to the Safeguarding Process and to address any issues that cannot be resolved at the Operational Group Meeting. All Agencies continue to confirm that the Operational Group is working well.

Resettlement/Delayed discharges

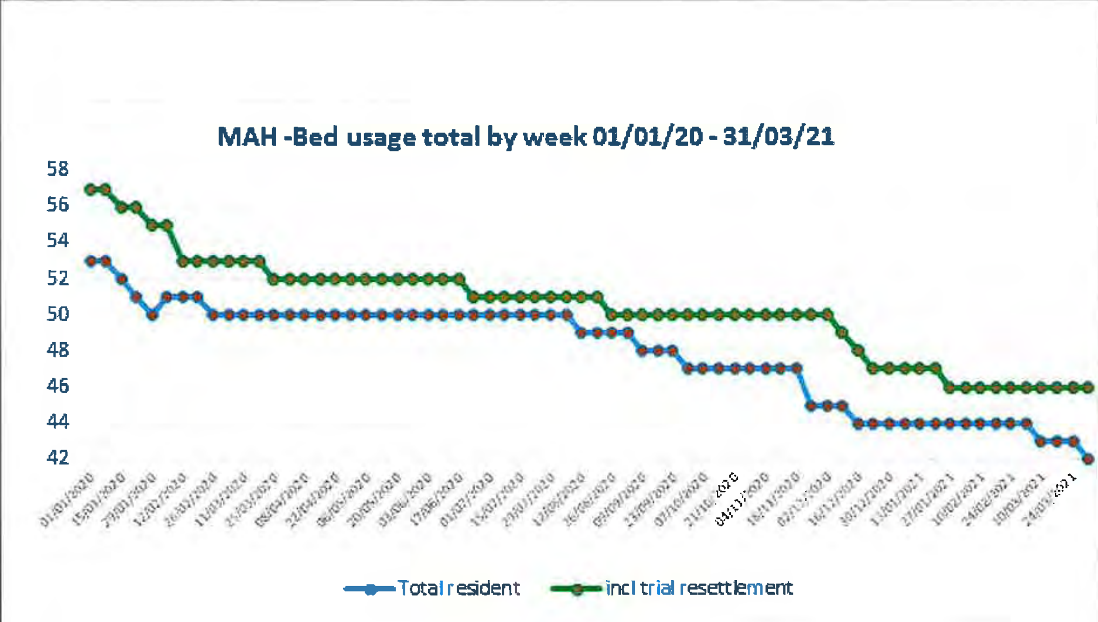
- As at 19 April 2021, the number of patients in residence was 42 with 1 patient on trial resettlement and 3 patients on Article 15 trial leave.
- One patient continues on extended home leave at the request of family.
- Of the patients on site only 1 currently is under active treatment – all other patients are delayed discharges.

The table below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement.

Inpatients (inclusive of patients on home leave) and Patients on Trial Resettlement

Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	19	1
Belfast HSC Trust	14	2 (Art 15)
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	0	1 (Art 15)
Total	**42**	**4**

MDAG/08/2021



Resettlement – Success and Failure Rate 20/21

	2020/21			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned	**Ongoing Resettlement**	**Success Rate**
BHSCT	2	0	2	**100%**
NHSCT	2	0	1	**100%**
SEHSCT	1	0	1	**100%**
WHSCT	0	0	0	**N/A**
Total	**5**	**0**	**4**	

Stabilisation

Nursing Staffing Position

- Current nurse staffing levels, with the combination of substantive nursing staff, long-term agency staff and nurse bank staff, are currently providing a safe level of care, supported by use of the nursing model. The Trust's 12-month Service Level Agreement with Direct Health Care agency to provide 50 whole-time equivalent (wte) registrants on a block booked basis in an attempt to stabilise the registrant workforce remains in place.

- However, the fundamental vulnerabilities of the workforce remain, namely the high levels of temporary agency staff combined with the ongoing PSNI investigation, which may result in further substantive staff being suspended. The Trust continues in its efforts to recruit substantive staff, with rolling advertisements for Band 5 and Band 3 staff.

- A total of 10.0 wte Senior Nursing Assistants (Band 3) joined the team since the end of January 2021.

- There were 3 successful candidates in recent Band 5 interviews held in December 2020. All candidates are currently nursing students and will take up post in summer 2021 following their successful completion of their course and registration.

- There are a further 15 Band 5 candidates to be interviewed and 24 Band 3 candidates to be interviewed.

- Three permanent appointments have been made at Band 6 level with a further advertisement for additional posts – this file has not yet closed.

- The summary staffing position at 5 April 2021 is set out in the table below (the term 'reg' is used to describe nursing registrants and 'non-reg' to describe non-registrants).

Nurse Staffing

	Plan wte *	Trust Staff wte	Agency Staff wte	Other Backfill wte	Variance after Backfill	% shifts filled against plan
Total	**181.63**	**73.94**	**71.63**	**25.51**	**-10.55**	**94.19**

**Figures exclude those on sick leave, maternity leave and annual leave*

Staff suspensions

- 69 members of nursing staff are on precautionary suspension, of which 33 are registrants and 36 are non-registrants.

- 3 staff have been dismissed; 1 registrant and 2 non-registrants.

Patient Safety

- A weekly Safety Report provides assurance on patient safety metrics which is reviewed by the senior management team in MAH, shared with the multi-disciplinary team and shared and discussed at the monthly Directors' Assurance Meeting, chaired by the Chief Executive. There is also a weekly Live

Governance call for all clinical areas to feedback on the previous week's incidents and any other governance issues. The Safety Report and the Live Governance calls have continued during the pandemic.

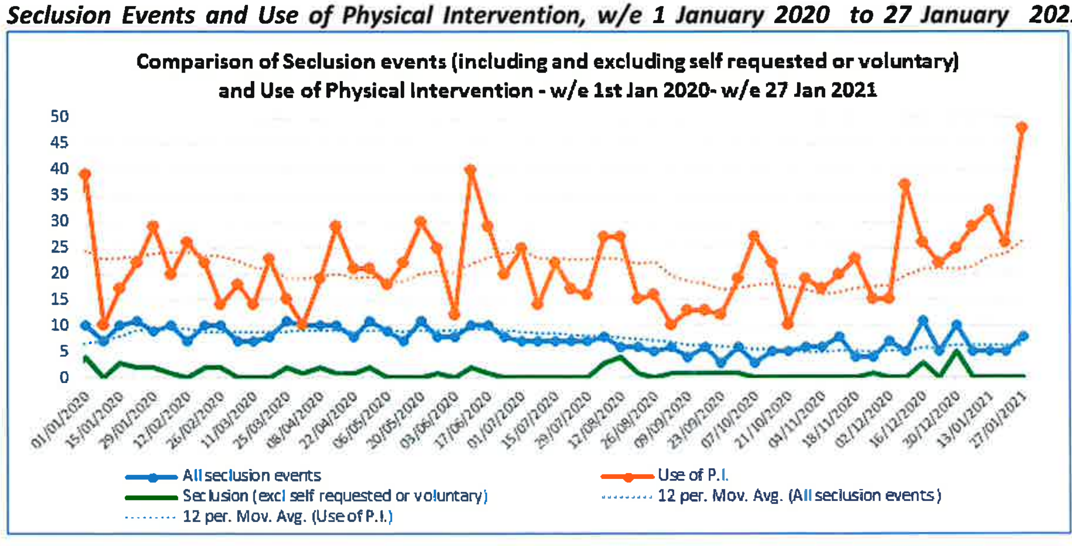
- To mirror the Quality Management System that has been established at Executive Team level, a daily meeting between the operational and senior management team is being piloted, at which relevant issues on the Muckamore site are escalated and discussed.

- Review of contemporaneous CCTV is continuing and this is used to provide feedback to staff on good practice, as well as providing an overall assurance to the management team. The Trust is continuing to explore options to use the CCTV footage as a training tool.

- In addition there are ward level clinical improvement groups, held on a monthly basis. At these meetings, ward-specific datasets are provided by the Quality Improvement Manager. These datasets help ward teams review trends and outcomes from the work that they engage in and provides them with convenient, visible information to highlight potential areas for change such as training needs, environment and workforce.

- The graph below shows the use of seclusion and physical interventions up to 27 January.

Seclusion Events and Use of Physical Intervention, w/e 1 January 2020 to 27 January 2021



Covid-19 Surge Planning and Implementation

- The focus of the management team and the staff in MAH has been, and continues to be, the protection of patients and staff during Covid-19. A comprehensive surge plan has been in place since March 2020, which RQIA and HSCB endorsed.

- As at 19 April 2021, all outbreaks have been closed and family and carer visiting re-established in line with DOH Guidance. All patients who tested Covid-19+ have recovered, and staff who have tested Covid-19+ have returned to work.

RQIA Improvement Notices

- An RQIA inspection of Muckamore was carried out on 27 and 28 October 2020. RQIA subsequently issued questionnaires to families to seek feedback. The RQIA provided verbal feedback to the Trust on 11 December 2020 and the final report was received on 5 March 2021. Four new areas for improvement were identified. The Trust have responded via the Quality Improvement Plan (QIP) Process and are currently working towards delivery of recommendations.

- RQIA undertook an unannounced inspection of Erne Ward on 22 January 2021 as a result of a whistleblowing complaint. Verbal feedback was given at a meeting on 29 January 2021 and the final report was received on 19 April 2021.

Carer/Family engagement

- There have been 98 applicants for the Carer Involvement and Personal and Public Involvement (PPI) Lead for Learning Disability services (adults) post which is the renamed Care Consultant post. Shortlisting is currently being completed.

- The first relaunched meeting of the Muckamore Carer's Forum took place on 10 December 2020, and a second meeting took place on 12 January 2021. Four meetings have now taken place since the relaunch – there are currently 4 patients who have been represented at the various meetings by family however advocates have been in attendance at each meeting.

- A Muckamore carer commitment statement and a carer's agreement have been developed by the Belfast Trust – these will set out how often family members want to be contacted, who they want to have as a key contact person, how they want to be communicated with, and what meetings they want to be invited to. Following feedback from families this has been revised and will be reissued and completed through the Assistant Service Managers and the Multi-Disciplinary Team in agreement with both patients and carers. This will commence w/c 26 April 2021.

- A questionnaire devised by the Belfast Trust was issued to families w/c 25 January in order to capture their feedback about a range of issues associated with having a relative in Muckamore Abbey Hospital. The questions posed cover issues such as quality of care, treating patients with dignity and respect, and staff response to queries. The findings of this are to be shared at the Muckamore Carers Forum on 20 April 2021.

- Work has commenced with the "Real Time Patient Feedback" team as to how best to capture the patient experience on the Muckamore site. The MAH Patient Council and Telling It Like It Is (TILLI) reference group have reviewed questions and made suggestions to make them suitable and relevant to patients with learning disability. This has been completed in conjunction with Speech and Language Therapy using Talking Mats. The suggestions have been fed back to the Trust Patient Experience Manager and a further meeting is planned for 22 April 2021 to determine whether revised questions fit with the Patient Experience domains.

- Four meetings have now taken place with representatives from Families Involved NI to develop Terms of Reference for a review of advocacy services. A review of advocacy services is a recommendation of the Leadership and Governance Review of Muckamore Abbey Hospital, 2012-2017. A final draft is now available and will be shared with HSCB and other Trusts in April 2021

Learning Disability Service Model Transformation Project

- The 'We Matter' Learning Disability Service Model, a High Level Consultation Summary, live Strategic Delivery Plan and an Equality Screening (which is currently under way) will be submitted to DoH on 14th May.

Independent Review of Acute Care services

- The Acute Care Review was completed and work undertaken to consider the development of a consistent model of Community Based Assessment and Treatment for individuals who present with challenging behaviour, Autism Spectrum Disorder (ASD) and/or forensic needs. An initial draft and subsequent redraft of the Community Based Assessment and Treatment (CAT) for People with a learning disability and Complex Needs approach have been shared with the Task and Finish Group. A further meeting was scheduled for 16th April – to discuss comments on the draft.

MUCKAMORE ABBEY HOSPITAL
What is Different Now?

'The true measure of any society can be found in how it treats its most vulnerable members'
M.Gandhi

1. Introduction

This paper is the product of a conscious new process of drawing on the combined expertise and experience of the Trust's Executive Directors for Social Work, Medicine and Nursing with one or more Service Director to make corporate sense of what's going on in any of the Trust's services – in this case Muckamore Abbey Hospital.

The spark for this piece of sense making, and arguably for this collective approach, was the Board discussion about Muckamore Abbey Hospital on 21 September 2020. In that meeting, whilst Trust Board was in receipt of and discussed a Muckamore Safety Report, there was a sense that the Board was searching for something more meaningful. At one point in the conversation the Chairman asked, '*What's different in Muckamore*?' This paper is our response to that question.

This paper is not a performance report. The core management information is now shared monthly with Trust Board through the Quality Management System. However, this paper has been informed by the ongoing development of the QMS system. Nor is it a safety report, but again it has been informed by the weekly safety reports.

In considering what is different about Muckamore now, we are inevitably drawn to what is not different. In considering Muckamore, we are also inevitably drawn to how the organisation and the HSC landscape as a whole has responded and changed, and how it has not. Institutional abuse of some of the most vulnerable in society within a Health and Social Care Trust, an organisation built on the values of care and compassion, is a betrayal – we must ask ourselves, have things changed? And what of the rest of the organisation – have the lessons of Muckamore been applied across the Trust?

2. Context

There is a high prevalence of abuse of people with a learning disability. Instances of institutional abuse are in the public consciousness, recognisable by name - Winterbourne View, Whorlton Hall. In Northern Ireland, Muckamore Abbey Hospital is now synonymous with abuse, abuse which we now know definitively was taking place in 2017. While we do not know when it started, the 2012 Ennis Ward investigation was a missed opportunity to seek assurances that abuse was not happening across the site. We will never truly know when abusive behaviours towards our patients began and went unreported.

The Care Quality Commission in England commissioned Professor Glynis Murphy to conduct an independent review to look at whether the abuse of patients at Whorlton Hall could have been recognised earlier by the regulatory process. In addition, CQC asked Professor Murphy to conduct a review of international research evidence to look at how abuse is detected within services for adults with a learning disability and autistic people, and how such detection can be improved. In '*Detection and Prevention of Abuse of Adults with Intellectual and Other Developmental Disabilities in Services: A Systematic Review'* (Collins and Murphy, 2020), the authors describe key risk factors for abuse and 'protective' factors against abuse and note 'it is unsurprising that the risk factors for abuse have largely remained consistent over the last 30 years'. A summary of these factors can be found in Appendix 1.

A further report published by the CQC looks at the use of restraint, seclusion and segregation in care services operating in England today for people with a mental health condition, a learning disability or people with autism. Its section 'What does good care look like?' is a useful synopsis of good practice in the care and treatment of people with challenging behaviour associated with learning disability, autism and other mental health needs. The relevant guidance is from NICE, notably NG 11 'Challenging Behaviour and Learning Disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges'.

Good practice in this setting typically recommends

- Specialist assessments and interventions based on the principles of positive behaviour support
- Importance of family involvement and support
- Staff trained in delivering physical interventions in a safe way
- Physical intervention used as a last resort, for the shortest possible time and in the context of a properly constituted care plan
- Staff competent in and supported to deliver interventions and also proactive strategies that reduce the risk of challenging behaviour
- Staff given emotional support which recognises that working with people with severe challenging behaviour can have a physical and emotional impact on staff which may have a negative impact on their therapeutic relationship with patients
- Environments homely and personalised, with access to secure outdoor space and a range of activities and interests of relevance
- Environments adapted for people with autism – managing noise, lighting, smell and movement

3. Service Delivery

3.1 Admission Pathways

What is different about Muckamore Abbey Hospital is that we are caring for 50% less patients than in 2017 when the bed occupancy hovered around 90 patients. In February 2021, we have 44 inpatients. There is also a key difference in that Muckamore has been closed to admissions since December 2019 and as a result hospital admission has stopped being the default option for any patient with a learning disability who becomes mentally unwell. On average in each of the three years spanning 2015/16 to 2017/18 there were 100 admissions to and 110 discharges from Muckamore. In 2019/20, the year prior to the emergence of Covid-19, there were 10 admissions and 23 discharges, and in 2020/21, there have been 0 admissions and 8 discharges.

The lack of an admission pathway into Muckamore is a significant change not only for Muckamore but also for the region – the impact has been felt widely across all Trusts. There is a high level of understandable concern and frustration at the loss of this pathway which represents a risk that those with a severe learning disability who require assessment and treatment for their mental health will not be able to access it. SHSCT and WHSCT both have their own inpatient units and can avail of beds but for colleagues in NHSCT and SEHSCT, their commissioned service is Muckamore.

All three Trusts, which includes ourselves, who historically used Muckamore as an admission pathway have had to seek the support of their own mental health services. In the period March to October 2020, there were approximately 14 requests for admission to Muckamore from within the Belfast Trust community team. Seven service users were ultimately admitted to a mental health bed. While there is recognition that mental health services represent an appropriate option for a service user with a mild learning disability who becomes mentally unwell, there is considerable debate about the role of mental health services when a service user has a moderate learning disability. There is evidence that people with a learning disability admitted to specialist behavioural units have more than double the mean length of stay compared to being admitted to generic or mainstream units (Saeed H., et al (2003) and Xeniditis K., et al (2004)). It is however universally accepted that a service user with a severe learning disability who requires assessment and treatment for mental illness requires the input of those with training and experience in the field of learning disability. There is therefore a need for an admission pathway to be re-created – the current position of being 'closed to admission' is not sustainable.

The Divisional team in Muckamore are currently developing a proposal for the reopening of 3 beds to provide an Assessment and Treatment Unit for patients with a severe learning disability. The only basis on which this will be viable is to timetable the reopening of beds following the next cohort of successful resettlements, so that the staffing resource which is released as patient numbers reduce is diverted staff an Assessment and Treatment Unit.

3.2 Resettlement

Resettlement is the term we use to describe the discharge of one of our patients from Muckamore to a community setting, which offers them betterment. This has always been and remains a priority for the Trust, and indeed for the three Trusts for whom Muckamore is their commissioned inpatient service.

As we know, in December 2018, the Permanent Secretary said that 'no one should have to call Muckamore their home' when there are better options available for their care; he added that the resettlement process would be complete by the end of December 2019. This target was missed.

People with a learning disability began to be resettled from long-stay hospitals in Northern Ireland from the late 1970s onwards. In the early 1990s there were more than 880 learning disabled people living in hospitals, however, progress with resettlement was slow. In 1997, the Regional Strategy for Health and Wellbeing stated 'by 2002, all remaining long-stay patients are to be resettled'. This target has been re-stated in at least five separate policy statements since this date, at each stage mandating the end of long-term admissions and the use of the hospital as a permanent address. Most notable among these was the Bamford Review of Mental Health and Learning Disability, an independent

review of legislation, policy and service provision which was commissioned in 2002 and which reported in August 2007.

The Bamford Review called for a renewed impetus to resettle the substantial number of people who at that time 'remained unnecessarily' in long stay learning disability hospitals. Leading a fuller life through active participation in the community was a key theme in the Bamford Review reports, particularly '*Equal Lives: Review of Policy and Services for people with a Learning Disability in Northern Ireland'*. The Executive's response to the findings of the Bamford Review, 'Delivering the Bamford Vision', was consulted on in 2008 and led to the publication of the Bamford Action Plan 2009 – 2011, and then the Bamford Action Plan 2012 – 2015. This latter Action Plan called for the resettlement of all remaining long stay patients from hospital by 31 March 2015.

While there has been a huge reduction in the number of inpatients in Muckamore there is much still to be achieved – 10 of our patients have been in Muckamore for more than 20 years and the longest resident has been with us since 1976. In designing our future model for inpatient learning disability services, we need to design-out the factors which have brought us to a point where patients spend their entire adult life in hospital. Let us never become numb to the abnormality of someone being in hospital for over 40 years.

Muckamore Abbey Hospital has a renewed focus on resettlement following the initial Covid-19 surge and associated lockdowns which inevitably delayed planning processes. What is different about Muckamore now is the loss of organisational memory and expertise which has arisen due to the retirement of the Division's full time planning manager who was incredibly experienced in respect to accommodation planning, business case writing and negotiation with the Housing Executive, HSCB and other stakeholders. This loss of knowledge and expertise which rested in a single individual, in addition to the cessation of a range of business cases that he was progressing, has undoubtedly contributed to a very sluggish 12 months. While we successfully recruited to the position in February 2021, experience will only be gained with time, and time has been lost.

What is also different about Muckamore now is that we have families prepared to invoke Judicial Review over the delays their loved ones have experienced being resettled from Muckamore. One case in particular is anticipated to generate high publicity when it is heard in the next number of months.

3.3 Community Infrastructure

In 2009, the NI Audit Office produced a report 'Resettlement of Long Stay Patients from Learning Disability Hospitals'. It highlighted that '*all three policy strands – resettlement, short term assessment and treatment, and community provision – must be developed and resourced simultaneously if the overall policy objective of resettlement of long stay patients is to be achieved*.' The NHS England document 'Building the Right Support' (2015) described our challenge 'as much about preventing new admissions and providing alternative care and support, as it is about discharging those individuals currently in hospital'. The diagram below is taken from this document:

In 2019, BHSCT community services adopted the NHS England 'Blue Light Protocol', also known as the 'Care and Treatment Review' approach – essentially, an escalation protocol to prevent unnecessary admissions and to identify and resolve barriers to supporting a service user to stay in their home. It is a framework comprising a set of prompts and questions to be considered by an MDT when a service user's mental health is deteriorating or when a provider appears to be struggling to maintain a service user's safety in the community. We have relied on increased care packages, shared care arrangements, wrap around psychology, behavioural services and other supports, short breaks and the flexibility of community staff to work outside their normal working patterns.
Inpatient mental health beds in AMHIC are also regularly used for the assessment and treatment of people with a learning disability who have a mental health crisis. However, the majority of those with a moderate and severe learning disability who would previously have been admitted to Muckamore have been supported to stay in the community. The Trust has received funding for the development of an intensive treatment team, which is essentially a crisis response team which can respond 7 days/week to a service user in the community who requires additional support. The service is not up and running due to a variety of reasons – for example, recent attempts at Consultant Psychiatry recruitment into this team was fruitless. The development of a 7/7 intensive treatment team requires our focus in 2021.

4. Our Patients

4.1 Experience

Our patient's experience must be considered from different perspectives. Safe care is paramount, but the nature and quality of the care must be equally understood – is it kind, is it compassionate?

Patients who have been living in Muckamore Abbey Hospital prior to August 2017 will have experienced a different type of care to the care they receive today. Prior to staff being aware that CCTV was operating, a number of patients suffered from regular physical and emotional abuse by those entrusted to care for them. We have 9 patients, who between them have to date been identified in over 1,300 incidents, still living in the same place where they were abused. We have not been able to interview these patients as part of the historic adult safeguarding investigation and therefore the impact of their experiences remains untold and unknown to those charged with their care today. Many of these patients are non-verbal and may only be able to physically express the impact of their experience.

It will be important for the Trust to map out each patient's experience of abuse during the period of the historic investigation to provide a picture of what they went through as a way of informing their future care and support needs. The impact that this has had on families and carers must be profound and in particular for those families who continue to entrust their loved ones to the same organisation which has let them down so badly.

What is different about Muckamore now is that we have real time access and viewing of CCTV which gives an up to date insight into the care being given. The vast majority of these accounts reflect kind and compassionate care – one extract from December 2020 described the footage as a joy to watch, see below :

'Patients appeared motivated, engaged and content. Staff members observed actively engaged in patients care on a 1:1 and group basis. Day care staff also observed in outreach activity, puzzles and hand massage (C24 09:53 + C28 10:00). Ward staff also replicated activity with patient (C24 12:20) motivating patient to complete jigsaw/puzzles. Other patients were accompanied off ward for walks. Staff members were responsive to patient's needs and were observed providing 1:1 compassionate care and appropriate touch (C22 11:00). One patient appeared to become agitated (C28 13:35) and received support and reassurance from staff members and day care staff. He was subsequently accompanied off ward for a walk and received a therapeutic hand massage when he returned to ward (C28 15:42). Staff members worked very well as a team and appeared to positively enhance the living experience of the patients in their care. This shift was a joy to view.'

This extract clearly demonstrates the activities and interactions staff were having with patients – this is an important factor in averting boredom, a risk factor in escalation in behaviours. While Covid-19 has effectively stopped a large number of off-site trips, such as farm visits, and on site activities facilitated by external organisations, such as Wee Critters, there continues to be a focus on ensuring a range of opportunities and activities are available for patients.

At the same time, there are also observations from CCTV viewers that some patients appear not to be engaged with by ward staff - it is hard to gauge whether this is because there are no activities available/offered at all or whether the time period being viewed is a time when a patient does not have an activity scheduled or has completed one earlier in the day or off the ward. Feedback from patients on their levels of boredom will be one useful aspect of the patient experience work we will discuss later.

We are not able to comment on the extent to which proactive feedback was sought from patients about their experience of living in Muckamore before the discovery of the CCTV footage in 2017. There are examples of this happening in Muckamore today, designed around specific events, or groups, for example, the ARC project, involvement of TILII, the Patient Council in Sixmile and more recently the Service Manager scheduling 1:1 time with patients to ask them about their experiences. The Trust wide Patient Experience team captures real-time feedback from hospital inpatients and reports back regularly from ward to board– their strength is their independence, their standardised methodology and immediate feedback loop. Their service does not currently extend to community settings or

Muckamore Abbey Hospital although a small Working Group has recently been established to agree how this can be adapted for learning disability services.
The 'Feel Safe and Happy' project which was considerably delayed due to Covid-19, has now commenced. This project is being delivered by the organisation Achieving Real Change (ARC), an intensive creative project which will use a range of approaches and techniques to explore how safe and happy our patients feel in Muckamore. This will offer an important evidence based baseline for future work in this area. The range of activity resources include reminiscence therapy, talking mats, social stories, arts and crafts, emotion barometers, 'Good Days, Bad Days'.
Therefore, what is not different about Muckamore Abbey Hospital is that we still do not have a regular and embedded mechanism of seeking patient experience and feeding it back into the management system. Our CCTV reports do give us a visual indication of what patients experience, some of our patients feedback to staff in the course of their interactions and feedback is sought through specific initiatives as describe above. We also have advocates who support some of our patients to tell their story. But the fundamental lack of regular feedback remains a gap and we need to explore with our Patient Experience corporate team how to do this in the learning disability setting.

4.2 Safety

What is different about Muckamore now is that we have ward-to-board reporting on a range of safety metrics, which monitor the use of restrictive practices across seclusion, voluntary confinement, chemical restraint, physical restraint and physical intervention as well as the number and nature of adult safeguarding incidents involving patient-patient incidents and staff-patient incidents. The Early Alert system to the Department of Health, and the Serious Adverse Investigation protocol are both utilised when the respective definitions are met and Significant Event Audit methodology is used across the site following incidents where there is opportunity for learning.
Safety parameters demonstrate a significantly different and improved picture across these aspects of safety compared to the CCTV footage which showed frequent use of seclusion, overuse of PRN medication and high levels of physical restraint often not in keeping with MAPA principles. RQIA's most recent inspections – the site wide inspections in December 2019 and October 2020, and the more recent Erne Ward inspection – have provided further assurance that our regulator is satisfied that care is safe today. This is different to the perspective RQIA had of Muckamore in the preceding period.
Yet we also know that there continue to be a high number of adult safeguarding referrals involving our patients, whether as a result of incidents between patients, or involving staff. We know that an open ward with patients living together in groups who may have a moderate or severe learning disability, as well as autism, is not an optimal environment. The communal living, open spaces, noise, lighting and unpredictability of interactions creates risk factors for incidents between patients to occur. However, this does not mean that we have an attitude of 'this is the way it is'. We know that through our Adult Safeguarding Forum, that there are individual patient and ward discussions about what practical steps can be taken to address and to prevent such incidents; for example, analysis has looked at whether there are particular times of the day, or particular patient relationships, which generate a high number of referrals. There are good examples of interventions which have resulted in a reduction in incidents, for example the use of pods. Other approaches include the role of positive behaviour support, ensuring that patients are occupied through staff interaction and activities, and the review and adjusting of patient observation levels.

4.3 Adult Safeguarding

What is different about Muckamore now is that in both RQIA inspections in December 2019 and October 2020, RQIA were assured that there were adequate adult safeguarding arrangements in place as evidenced by speaking to staff and reviewing records at ward level. In practice, there are a number of areas where managers are unclear as to their roles vis-à-vis those of adult safeguarding, and this has created tension at local level and challenges among the senior team. A number of interventions

have taken place, including training for managers, HR and Adult Safeguarding colleagues. The respective roles of adult safeguarding and HR processes continue to present some points of difference - these areas need addressed and indications are that they are not unique to Muckamore.

As we know, staff who worked on site in 2017 and who remain in work have either not been identified on the CCTV footage, or have been identified as failing to intervene when harm was being caused by others. These 27 staff continue in work under enhanced training and supervision as part of an adult safeguarding protection plan which is not as robust as it should be due to the PSNI restrictions on disclosure. This has been highlighted by the Divisional Social Worker and Adult Safeguarding Champion for some time and more recently both RQIA and the Department of Health (December 2020) have urged the Trust to address this in so far as possible within the confines of the PSNI investigation. RQIA and DOH have also flagged the lack of involvement of a DAPO in the regular review of the training and supervision plans as a weakness. This has recently been addressed.

The Adult Safeguarding Team in Learning Disability services, and more specifically the team who support Muckamore Abbey Hospital, are struggling to meet demand as a result of a number of longstanding vacancies of the Adult Safeguarding Lead and DAPOs. These posts have recently been recruited to but further expansion in the core team is required given the complexity of these investigations and the range of stakeholders involved. In addition, there are no Investigating Officers in Muckamore. Given the hugely important role that our safeguarding team have in investigating incidents, responding to and updating families, and being as responsive as possible for everyone's sake, there is an urgent need to further invest in this team/service.

The introduction of the QMS for Learning Disability (January 2020) highlighted a further area of weakness in respect of adult safeguarding data – resource is needed to assist the service to have timely access to good quality data which tells us what we need to know about our adult safeguarding referrals, their subject matter, investigation timelines and outcomes. The DOH have asked the Trust to provide an analysis of our adult safeguarding activity which should be completed by mid March 2021. Our aim is to agree a minimum data set and reporting frequency so that such a report becomes part of our core business.

5. Family and Carers

We have a number of different groups of families associated with key events in the chronology of Muckamore - the first is the investigation which was carried out into Ennis Ward in 2012; the second is the CCTV footage associated with the period April to August 2017. The family groups are those :

- known to the historic investigation team whose loved ones are still in Muckamore
- known to the historic investigation team whose loved ones have left Muckamore
- whose loved ones were in Ennis Ward during the 2012 investigation
- whose loved ones were in Muckamore between 2012-2017 but not known to the historic investigation team nor the Ennis Ward investigation
- whose loved ones have been admitted to Muckamore since August 2017

A Family Liaison Officer supports the families of patients who have been identified as victims of abuse from the CCTV footage for the period April - November 2017. They are aware of all the incidents which have come to light involving their loved ones, but not which staff have been involved. They are aware that a significant number of registrants and non-registrants have been placed on precautionary suspension but are not aware that a significant number of staff remaining on site and caring for their loved ones are on supervision and training plans as part of the protection plan for their loved one. Both DOH and RQIA have asked the Trust to consider the extent to which this information should be relayed to families.

Following the release of the Leadership and Governance Review, families were extremely angry that they had not been invited to the publication launch event hosted by the Patient and Client Council. This oversight highlighted that the distinct areas of management responsibility assigned across Directors carries a risk of compartmentalising the Trust's approach to family engagement. Families felt let down by the Trust. Families described their experiences of the launch event and the Review as re-living the abuse. This re-living is exacerbated every time they are told of a new incident or when they hear another staff member has been arrested or suspended. Families have been traumatised by what they have heard, and are being re-traumatised as the story unfolds. A number are now receiving counselling.

What is different about Muckamore now is that for the families and carers of those who suffered abuse, the trust and confidence they had in the organisation, the leadership and the staff involved has been irretrievably destroyed. Families describe the devastation and bewilderment of the initial news and how it grew as details started to emerge and be shared. For those families who have loved ones in Muckamore who have not been identified as victims of abuse, there appear to be mixed emotions. A number of these families at an event hosted in Muckamore with the Minister spoke very passionately about their support for the staff in Muckamore and for their gratitude for the care being provided.

We don't really know what relationships with families and carers were like before the abuse was discovered other than a few instances where families have expressed how much of a shock it was to learn about what had happened. This suggests that prior to the revelations, there was a certain amount of confidence in the care being provided. The relationships we have with our families are complex - far from uni-dimensional. Ward teams have worked hard to maintain communication with families and update them on how their loved one is doing, a particular challenge during Covid-19. The survey that has been recently issued to families asks them how satisfied they are with the care and communication they receive from the hospital and also the extent to which they feel involved in their loved one's care. The feedback will give us a new baseline from which to identify what we need to do to improve this important relationship.

The re-establishment of trust and confidence will take a considerable amount of time and for some families may never be restored – the impending inquiry presents a further opportunity for any ground gained to be eroded. The recent public engagement events convened to shape the Terms of Reference

of the inquiry have seen a re-emergence of previous complaints and concerns, but also what appear to be some new complaints which are now being investigated for the first time.

The appointment of a Learning Disability Champion at Trust Board has served to reassure some families of the Trust's desire to address its failings and to embed the voice of those with a learning disability at the very top of the organisation. Some small operational steps have also been taken – the re-establishment of the Muckamore Carer's Forum, recruitment of a Public Involvement Lead for Learning Disability - a key appointment if we can find the right person, and wider engagement with our families through the use of the survey referenced above. The LD Forum, a community facing public involvement approach, will re-launch with the appointment of the Public Involvement Lead but the ability of staff and managers to converse and interact directly with our families in a regular, constructive and genuine way will be at the heart of how we move forward.

Our community families articulate false promises and a loss of confidence from the Trust not following through on the community LD Forum which was launched in September 2019. The vision for this Forum and its themed sub groups was to knit together staff, managers, service users and families in designing and delivering community services. The forum met once and then stalled when management time was diverted to Muckamore. What is different as a result of Muckamore is this sense of lost time for community services, something which we are only now returning to in earnest.

*The best advocacy is **uncomfortably powerful** because it engages with the immediate and pressing circumstances of an individual, most particularly an individual whose interests might otherwise be inadequately recognised and supported' - Margaret Flynn, 'A Way to Go', 2019*

With the discovery of institutional abuse in Muckamore, the question of how effective the advocacy arrangements have been for patients, service users and families has rightly been asked afresh. The review panel who conducted the Leadership and Governance Review spoke with representatives of Bryson House and Mencap. There is limited coverage of the issue of advocacy in the report, however the report recommends that the Trust review its advocacy services and 'develop them to ensure they are capable of providing a robust challenge function for patients and support for relatives and carers'.

What is not different about Muckamore Abbey Hospital is that Belfast and South Eastern Trust inpatients continue to avail of advocacy from Bryson House, while patients from the Northern Trust and Southern Trust avail of advocacy from Mencap and Disability Action respectively. Bryson House has a family advocate and all patients and families also have the Patient Client Council (PCC) available to them for advocacy. Since the publication of the Leadership and Governance Review, there has been a notable increase in the advocacy role of the PCC who have recruited new advocates specifically for learning disability/ Muckamore.

What is different about Muckamore is that we are actively designing Terms of Reference for a full evaluation of our advocacy arrangements. We are committed to seeking feedback from our patients, our families, our staff and our advocates to ensure that our advocacy arrangements are fit for purpose.

7. Staff Experience

We know that concerns were raised in 2012 about how patients were treated by staff in Erne Ward, and we know that many staff were engaging in behaviours that physically and emotionally harmed patients in 2017. A number of other staff witnessed these behaviours and failed to report them. When staff became aware that the CCTV cameras had been turned on behaviours changed and the frequency of patients being harmed significantly reduced. The historic investigation also identified that in 2017 there were practice issues, such as the excessive use of mobile phones by some staff on duty without appropriate intervention by members of the management team. There were also concerns about the lack of activities for patients and a picture emerged of a closed culture, whereby families were discouraged from entering the wards, and visitors were kept to a minimum.

As we know, staff who have been identified as causing harm have been placed on precautionary suspension and some have now been dismissed following completion of the Trust's disciplinary processes. Any staff remaining have either not been identified at all on the CCTV footage, or have been identified as failing to intervene when harm was being caused by others. These staff do not have a clear idea of what footage exists of them. And unlike with Winterbourne View and Whorlton Hall, footage has not made its way into the spotlight – it could be argued that had this happened, it would have addressed a concern among some staff that the incidents seen on CCTV are poor applications of MAPA techniques which have been misconstrued as abuse. As time progresses, with the increasing number of arrests and dismissals, our sense is that this view is diminishing.

Adult safeguarding incidents involving staff-on-patient continue to occur, however, data on adult safeguarding referrals for the period 1 October 2019 to 31 December 2020 shows that 70% of these incidents are now reported by staff. This reflects a significant cultural shift where we now have staff proactively coming forward to raise concerns and to report incidents involving colleagues. By contrast, only 5% of adult safeguarding referrals, a total of 5 incidents in the same period, were made following viewing of contemporaneous CCTV. There is now an increased visibility of managers with Assistant Service Managers based in the ward blocks and available to staff and patients. Covid-19 has removed the option of in-ward visiting, but prior to Covid-19, there were concerted efforts to address the closed ward culture by encouraging leadership walkarounds, visitors and members of the MDT to spend time in the ward.

What is starting to be different about Muckamore is a more pronounced recognition of the very challenging job that staff have. The highest number of incidents reported by staff relate to patient on staff assaults, and staff injury is a frequent occurrence. A Violence Against Staff Working Group has now been set up to look at what supports can be offered to staff who find themselves in these situations. There is also now a Trust wide Trauma Informed Practice Working Group – the introduction of TIP would support the staff to process the impact of these incidents on them personally.

Listening Exercises conducted with staff in late 2019 identified themes – notably:

- experience of working with constant staffing shortages and being pulled between wards for cover
- lack of a career pathway for registered nurses other than ward management
- lack of recognition for their role
- support for staff when incidents occur resulting in physical assault/injury
- lack of nursing leadership on site
- lack of visibility of senior management

In December 2019, RQIA reported that they found staff morale had greatly improved from their previous inspections. The recruitment to key leadership positions and the presence of consistent managerial support, regular dialogue between managers and staff, and opportunities to recognise and celebrate the many wonderful things happening on site have all served to boost morale. The social media profile around BHSCT learning disability services, including Muckamore, is now positive and uplifting. There is a greater sense of partnership working between staff and managers, and also between Trade Unions and managers on site. Muckmore is different in this regard.

Conversely, some staff who have worked in Muckamore for many years talk about the loss of pride they now have when they talk about where they work - some describe how they actively avoid it in conversation. What is different about Muckamore now is that caring and compassionate staff, whether substantive or agency, feel they are working under a cloud of distrust, which is fuelled by a low bar for adult safeguarding and by media reports to which there is no right of response. It is a worry that our most passionate and committed staff who bring their best selves to work may become weary of working in this context. Our Ward Sisters/Charge Nurses and Deputy Ward Sisters/Charge Nurses are a committed, enthusiastic and patient-centred group – meeting them and talking with them is to feel energised and optimistic. These staff represent hope for a brighter future – we need to retain them.

7.1 Nurse Staffing

What is different about Muckamore Abbey Hospital site now is the significant reduction in substantive nursing staff. There are 67 staff who previously worked in Muckamore who are suspended and in addition a number of staff have retired or resigned. As a result of critical staffing levels, the Psychiatric Intensive Care Unit closed in December 2018 and patients and remaining staff were redeployed to other wards on site. The sudden and significant loss of staff at the outset of the PSNI investigation led to huge instability and uncertainty about the viability of the site, and contingency plans were developed in 2019 in the event of an immediate need to close the hospital.

Staff suspensions have now slowed significantly and 3 years later, the service is being maintained through the use of high numbers of agency staff. The make-up of the nursing workforce in Muckamore is different now with the majority of registrants employed via agency - only 22% of Band 5 registrants are Trust staff compared to 85% of Band 3 staff. This is a grim picture.

However, the Nurse Bank has worked with the management team to ensure that the agency staff are offered block bookings - this has proven reasonably successful in that most of our agency staff stay for periods longer than 6 months. The majority of registrants are now recruited from one agency with whom we have a SLA to provide a sustained workforce of up to 50 staff. In an attempt to further integrate our agency staff and maximise their input, they are able to take charge of the ward once they demonstrate they have met a range of competencies. The long-term nature of these contracts and the ability of these staff to take charge is slowly instilling a sense that these are ‘our’ staff, not ‘agency’ staff.

It appears that Muckamore Abbey Hospital had long struggled to recruit nursing staff as reflected in the Leadership and Governance Review. However, alongside this we also know that there were a core group of staff who spent their careers in Muckamore and whose family and wider family also worked on site. While this feature of the site has not been eliminated, the scale is much reduced.

What is also different about Muckamore Abbey Hospital now is that we have an agreed nurse staffing model which is used to calculate safe nurse staffing levels. The model uses a Telford exercise to identify the number of registrants required per shift, alongside prescribed levels of patient observation as determined by an assessment of each patient’s acuity and dependency. The nurse staffing plan is reviewed weekly to identify if each ward is achieving the necessary levels of nursing staff and prompts escalation through to the daily huddle. RQIA were satisfied during their December 2019 inspection that while staffing levels are not where they should be, Ward Managers are able to assess their current and future staffing needs using an agreed framework, and escalate the need for additional staff appropriately.

Recruitment efforts have been ongoing to recruit Band 6 and Band 5 Registered Learning Disability Nurses and Band 3 Senior Nurse Assistants – these efforts have resulted in small numbers of new appointments. There has however been real progress with recruitment into senior nursing positions on site which have offered promotion opportunities to our staff - in December 2019, 4 wte substantive Ward Managers were appointed and in September 2020, 3 wte additional Out-of-Hours Coordinators were recruited. Of note, one of the Out-of-Hours Coordinators (Band 7) appointed in September 2020 is one of our agency staff.

7.2 Medical Staffing

What is different about Muckamore is the significant reduction in Consultant Psychiatrists who work in the hospital - the numbers have fallen to a core staff team of 2.5wte, of whom 1.5wte are substantive staff. The remaining 1.0 wte Consultant is employed via an agency. There are small numbers of trainees coming through training and one SpR is now eligible for a Consultant position.
As patient numbers fall on site, the need for medical cover will reduce however the availability of physical health assessment and screening of this vulnerable population must remain secure. A locum Speciality Doctor with an interest in Physical Healthcare has been recruited to Muckamore who has been a huge asset. The future direction of travel is towards the community and therefore any new Consultant posts should sit within community services; striking a balance between growing our community team while sustaining the hospital service may be difficult.
A recent NIMDTA report on training of junior medical staff in December 2020 was very positive –one observation was the limited/light training opportunities associated with providing input to a predominantly delayed discharge population.
There has been no Chair of Division since 2019, however, it is anticipated that this post will be filled in the near future. The addition of a Chair of Division will complete the Divisional Team and represents a timely opportunity for the Team to come together to discuss and reflect on their respective roles within the collective leadership context. The ability of this team to pull together will be key to its ability to meet the challenges described in this paper. Recent discussions around adult safeguarding and practical implementation of safeguarding procedures have exposed different understanding and approaches which require clarity for all concerned.
The more operational role of Clinical Director (CD) is now vacant due to maternity leave which represents a risk to the service given the very hands on role that the CD has across hospital and community services. There are no interested candidates from within learning disability services however the impending appointment of a Chair of Division from outwith the service may generate more interest. The appointment of a Clinical Director is a pressing issue.

7.3 Service Management

Muckamore Abbey Hospital has 44 inpatients. In other parts of the Trust, this number would be equivalent to 1 or 2 wards. Muckamore accounts for 2% of the Trust's overall spend, and its headcount is just less than 2% of Trust staff. The service management and senior management input to this service is hugely disproportionate to its size – the scrutiny, accounting, responding and reporting required regarding every aspect of this service is relentless, outwith normal control limits for obvious reasons.
What is different about Muckamore Abbey Hospital now is that the vast majority of the management team joined the Division after the discovery of the CCTV footage, or just prior to its discovery. This has minimised the risk of managers being compromised by their association with the past, however the almost total clear-out of operational management memory has certainly created delays for anyone picking up threads of partially completed work or returning issues from the past. There is now only one member of the management team who has worked on site during the period of the historic adult safeguarding investigation.
There have been recent successes with recruitment such that there are now no vacancies at Assistant Service Manager level and above, and this has achieved a real sense of stability. Recent recruitment is described below:

- January 2020 - 1.0 wte temporary Assistant Service Manager
- April 2020 - 1.0 wte substantive Co-Director for all of Learning Disability Services
- April 2020 - 1.0 wte substantive Service Manager for Muckamore Abbey Hospital
- September 2020 - 2.0 wte substantive Assistant Service Manager
- February 2020 – interview to be scheduled for Chair of Division (x1 applicant)

The question 'what is different' will get different answers from service managers in the hospital and community setting. From the Muckamore perspective, it is about stabilisation, restoration and recovery, respecting the harm and hurt of the past while seeking to support the service to learn and

to develop. From the community perspective, there is a tangible sense of being left behind when the organisation and management team had to turn the full force of its attention onto Muckamore. The creation of a dedicated Co-Director for Muckamore Abbey Hospital provided a management focus which the site needed at that point in time, but only served to reinforce a divide between hospital and community which had its own repercussions of disconnection.

What is different about Muckamore, and indeed learning disability services now, is its separation from mental health services. We remain the only Trust in NI where mental health and learning disability services are not managed by the same Director, bed fellows in the same Directorate. There is common ground and shared goals and learning disability services could learn a lot from mental health services if managed together, not least in how mental health services have developed their community infrastructure. Distinct units of management are not necessarily a barrier to effective working but the opportunity for regular interaction, information sharing and problem solving which comes from being around the same Directorate table has much to offer.

Much has been written about what is different about Muckamore now in terms of governance systems and processes. These were and remain an important part of any RQIA inspection and the inspections in December 2019 and October 2020 provided feedback that these systems are sticking. What is different about Muckamore is the existence of Live Governance, Daily Safety Huddles, a weekly Safety Report and ultimately the creation of a QMS dataset for Learning Disability. While the Leadership and Governance Review commented that such data has always existed, there appears to have been no line of sight of this data outside of Muckamore. This is different today.

9. The Rest of the Organisation

More so than ‘A Way to Go’, the Muckamore Abbey Hospital Leadership and Governance Review looked outside learning disability services and examined how the organisation was structured, how it operated and how Directors, Executive Team and Trust Board shared and acted upon information about the hospital. This Review had only limited input from senior leaders with responsibility for Muckamore in the period 2012 to 2017 but we can expect this narrative to be expanded upon with the inquiry.

What we do know about how Muckamore has shaped the rest of the organisation, is the resultant clarity of responsibility and accountability on all leaders to escalate early and be open and transparent about problems that are emerging in their services. There have been over 100 Safety Reports produced about Muckamore Abbey Hospital with a report going to Trust Board each month. This is different and in fact largely unique to Muckamore. The extent to which this level of reporting is sustainable for Trust Board is a matter for debate – at some stage this will need to be stood down, a test of confidence in the new arrangements that are being put in place in relation to the QMS and Assurance Committee.

This new collective process of sense making involving Executive Directors for Social Work, Medicine and Nursing with one or more Service Directors, is in its infancy. It has been hard to get off the ground but appears to offer a lot of potential as an approach, and one which could be rolled out across a wide range of services. It is also clear that there is a need for corporate attention, in a risk-based framework, to possible weaknesses in other services where care is provided to vulnerable patients or service users. This is an active theme in the current Social Care Governance Review.

10. The HSC Context

What is different about Muckamore Abbey Hospital now is the level of scrutiny being applied by other organisations in the HSC. There is a bi-monthly Muckamore Departmental Assurance Group co-chaired by the Chief Nursing Officer and Chief Social Worker, with representation from all Trusts, families, HSCB, RQIA and the Patient Client Council.

There are fortnightly Learning Disability Director meetings which bring together Trust Directors, HSCB, RQIA, and the Head of Learning Disability Services at DOH. These are an opportunity to both operationally problem solve and steer the strategic direction of learning disability services. Similar arrangements appear to have been in place historically through the Mental Health and Learning Disability Improvement Board but the latest iteration has been brought about to ensure that both MH and LD have equal time on the agenda.

RQIA continue to have an active regulatory role and have responded to a recent whistleblowing through an unannounced inspection in Erne Ward (December 2020). What is different is that we now have a more open and proactive relationship with RQIA.

11. The Future

What is different about Muckamore now is the level of uncertainty about its future – concerns abound about its closure even though the extant policy position is that it is not closing. There could be many reasons to close Muckamore – not enough staff which makes it not viable; patients are resettled which means there is no longer the need for such a large inpatient learning disability facility; the loss of public confidence in the service and the brand/name. Undoubtedly recruitment and arguably more so, retention, is hindered by the lack of a clear policy position on the future of Muckamore. The recommendation in the Leadership and Governance Review that consideration be given to which Trust is best placed to lead the service has only compounded the situation, adding a further layer of uncertainty.

A 'vision' for Muckamore cannot be described without considering the whole landscape of learning disability services. There is a continuum of need with an Assessment and Treatment Unit, ie. a hospital admission, the last option for a very small number of people who need it after all other options have been exhausted. We cannot design a service for this small group without understanding and designing the whole.

In recent months, there have been a number of documents produced. The first is the draft 'We Matter' paper from DOH which is the Adult Learning Disability Service Model for Northern Ireland This paper describes the need for each Trust to have its own acute inpatient assessment and treatment service as well as an enhanced community based assessment and treatment option, what we described earlier as intensive treatment support. This paper also sets out a shift away from a facility such as Muckamore which provides beds for 3 Trusts, to a model where each Trust has its own inpatient beds

The second document is the draft Strategic and Commissioning Plan for Learning Disability Services 2021 – 2024 produced by HSCB. This sets out a number of practical priority areas for development – this is a more granular paper which draws in a number of recommendations from 'A Way to Go' and the Muckamore Abbey Hospital Leadership and Governance Review. It is an early draft but with input from all five Trusts there is the potential that this can act as an operational roadmap for us all.

Neither 'We Matter' nor the Commissioning Plan describe what the future looks like in terms of the scale of the inpatient provision required, and in practice there is not a consensus among BHSCT, NHSCT and SEHSCT that each Trust could support its own inpatient unit. There is also a continuing debate about the number of beds actually required. Separate HSCB and tri-partite Trust discussions are ongoing and HSCB indicated at a meeting on 19 February 2021 that they will now be progressing a needs assessment to inform a consultation paper on the future model (shape and size) of inpatient services for Northern Ireland. Some simple questions need answered, for example, how many inpatient learning disability beds does a population of 1.8 million need. The completion of a needs assessment is a welcome development.

The DOH were undoubtedly responding to feedback they had received from families when they wrote to all Trusts urging caution about a 'resettlement at all costs' approach. This has further evolved with a letter from the Chief Social Worker asking the Trust to consider an option to allow a small number of our patients who have lived the majority of their adult life in Muckamore to be resettled permanently on site. An initial scoping by all three Trusts has identified a potential of 10 patients who may meet this very basic definition. This is something different for Muckamore, an opportunity to design a new future. However, the three Trusts have expressed a concern that if all families are made aware that there is a facility being developed on site or adjacent to Muckamore, some other families may choose to withdraw from resettlement plans which are already advanced. A discussion with the DOH and HSCB about how this proposal is handled with our Muckamore families is required and is being arranged.

For Muckamore, there is also the issue of Sixmile Ward, an inpatient low secure forensic ward for patients with a learning disability. There will always be a requirement for this type of ward, albeit analysis of new admissions and delayed discharges would indicate that the number of beds required is very small. The ward currently only has male patients– there is no provision for females, and there

is also no medium secure provision for patients with a learning disability in Northern Ireland. If patients require medium secure provision then they have to go to another part of the UK. The Mental Health and Learning Disability Forensic Network is being re-established and is likely to have a pivotal role in navigating these issues.

Describing a vision for Muckamore is to have a vision for its component parts, and to place it in a continuum of care, from community services, through to intensive treatment team, and an inpatient Assessment and Treatment Unit. In trying to describe a vision, we arrive at options – options which need teased out, challenged and discussed with our partners in health and social care and our families and carers. We have an opportunity to be bold in our vision but we should not seek to do this alone – much like this co-produced set of reflections, a vision for learning disability services and the future of Muckamore should be tackled collectively.

Components	**Options**
Intensive Treatment Service (Community)	1. Continue to progress recruitment and development of this service model
Low Secure Forensic Provision (Regional)	1. Remains on site 2. Relocates to Belfast : 2a. Co-location with mental health forensic provision 2b. Consider standalone service
Assessment and Treatment Unit	1. Is provided on site to serve 3 Trusts 2. Is provided on site to serve 1 Trust 3. BHSCT service only and relocates to Belfast
Supported Living and/or Residential Care	1. Convert MAH into a campus for supported living and/or residential care, either with other services adjacent as above, or stand alone. - This could be time limited for those identified as having spent their adult lives in Muckamore, or it could be a permanent fixture. 2. Progress supported living facility adjacent to MAH (existing scheme) and release site as other services are relocated and re-provided in Belfast

12. Conclusion

What happens in Muckamore Abbey Hospital is under constant, intensive scrutiny as part of our regular management arrangements in the Trust and beyond. What happens there is more visible than it was in the past, including to Trust Board. It is safer, it is better understood and we know that there are examples of incredibly compassionate care. However, it remains a high-risk service - it is inherently high risk.

When we really stand back, our sense is that as it is currently constructed, Muckamore offers an out-dated service model which is providing care in the wrong place, and at the wrong time and in a number of ways, by the wrong staff. The future is a much pared back hospital service sitting alongside a comprehensive community model, and predominantly a social care model not a nursing model.

Moving towards a new model of care requires very careful and sensitive management of our relationships with patients and their families - first and foremost. Secondly, it requires active, informed and persistent interaction with the Department of Health and the HSCB to influence regional planning. Over the past year we have demonstrated that we are at our most influential at the regional level when we are on top of our own business. That will be the case here. This paper can accelerate our prompting regional leadership in planning the future of this service.

Appendix 1

Detection and Prevention of Abuse of Adults with Intellectual and Other Developmental Disabilities in Services: A Systematic Review - Collins and Murphy (2020)

Risk Factors

Victim

Victim characterisation associated with increased risk of victimisation of abuse within services included:

- Gender, with females being more at risk of sexual abuse than males
- More severe learning disability and communication difficulties
- Known to services over time or since birth
- Escalation of challenging behaviour
- Previous abuse victimisation
- Involvement in individual behaviour management or being in receipt of a drug to control behaviour

Perpetrator

Individual characteristics associated with the perpetration of abuse included:

- Gender, with males more likely to perpetrate abuse compared to females
- Newer employees
- Previous perpetrators of abuse
- Staff inability to cope with increasing stress or staff's inappropriate means of relieving stress
- Staff perceptions of, or attitudes to, service user

Organisational

Organisational risk factors associated with a higher risk of abuse within services related predominantly to:

- Poor management
    - o Lack of managerial support for staff
    - o Negative relationship between staff and senior colleagues
    - o Need for staff training
    - o Resistance to change
    - o Barriers to collaborative working, eg. Lack of team meetings, reflective practice
    - o Poor communication and/or engagement with parents/carers
    - o Poor communication and/or engagement with commissioners
- Poor implementation of policy
- Inadequate monitoring of services
- Poor quality care plans
- Isolated or poorly maintained environments
- Poor processes for reporting concerns
- Minimal attempts to implement adult protection policies
- Staff shortages
- High staff turnover
- Poor recruitment strategies

Murphy (2020) states that more recent research suggests organisational risk factors and norms can create a culture of abuse characterised by

- Absence of caring values
- Isolation
- Ineffective staff supervision
- Intimidation
- Punishing regime

- Institutionalised practice
- Inexperience
- Anti-professionalism
- Barriers to disclosure
- Poor support for whistle-blowers
- Deficiencies in service audits
- Staff collusion
- Poor inter-professional communication
- Poor recognition of staff skills
- Lack of clarity in care management

Protective Factors
Service Users
Protective factors of service users include:
- An ability to report information, ie communication skills
- Knowledge of their right not to be violated
- Control over their own safeguarding, ie. Knowledge of how to self-report
- An understanding of social relationships, coping strategies and assertiveness skills

Staff
Protective factors related to the characteristics of staff include:
- Positive attitudes towards residents
- Acknowledgement and attendance to difference
- Recognition and respect for service user preferences
- Intrinsic motivation
- Confidence to challenge bad practice
- Having positive relationships with senior colleagues whereby staff feel listened to and valued

Organisation
Protective organisational factors include:
- Clear leadership of a manager whose values are aligned with those of staff and the organisation
- Clear guidance at work
- Supervisors who alongside staff, modelling, monitoring and correcting practice
- Good communication
- Shared decision making
- Embracing new ideas and external visitors
- Good connections with the community
- Good relations with the safeguarding team
- Regular staff training
- Independent staff appraisal and supervision
- Consistent use of disciplinary procedures for staff
- Support for whistleblowers
- Reflective practice
- Shared responsibility for practice quality enabling teamwork
- Person centred working practices

Protective factors create a caring culture characterised as coherent, respectful, enabling for service-users and motivating for staff.

Muckamore Abbey Hospital Stakeholder Summit

29 April 2021

Working together Excellence Openness & Honesty Compassion

Opening Comments

Welcome – and thank you for your participation

We recognise that the challenges we face in Muckamore Abbey Hospital have had significant ramifications for other parts of Learning Disability services

We cannot right the wrongs of the past but we can and must learn and need to work collectively to design and deliver a brighter future for people with a learning disability and their families. This is the least we can do.

We are grateful for the support and collaboration in difficult circumstances from our partner Trusts and all agencies here today

It is our collective energy, ideas and thoughtfulness that we want to harness today

We are not here to be defensive we need your expertise and sense making to ensure that no stone is left unturned and that we can be confident we are doing everything we can

While this represents an overview we are happy to share more information or talk further at another time if further analysis is re uired

We have tried to summarise key risks and primary actions but this is not exhaustive

Risks and Mitigations
Belfast HSC Trust

Historic Investigation

MAH Historic ASG Team comprises of the following temporary staff:

Service Manager
1.8 wte Band 8As - DAPO
4 Band   CCTV viewers   DAPO
1 MAPA viewer
1.2 wte Family Liaison Officer Social workers
1 Data Analyst
1 Administration Officer

2 x Senior Nurse Advisor

HR Senior Manager
5 x HR Staff

Divisional Nurse for MAH

Historic Investigation

Key Role of the Staff

View raw footage to identify incidents of concern, where appropriate. Initiate referrals to senior management via HR for interim protection plans and where appropriate refer to PSNI.

Decisions in relation to staff following identification of Incidents of Concern

Implementation of robust Protection Plans

Notify and support affected families where incidents of concern are identified. This includes cross-Trust liaison work

Support the PSNI investigations through provision of additional information

Support the Trusts Disciplinary Process

Historic Investigation

Viewing of CCTV footage

Completed Safeguarding viewing hours by th October 2020

Ward	Night	PM	AM	Total hours viewed	Total hours to be viewed	hours viewed	Hours remaining to be viewed
Cranfield	1628	95 .5	958.5	3544	3552		**00**
Cranfield 2	161	955.50	962	3534	3552		**0**
PIC	1628	962	962	3552	3552	**00**	**0**
Sixmile A	2013	1001	1001	4015	4440	**0 3**	**2**
Sixmile T	33	832	858	1 23	4464	**3**	**2**
Grand Total		**0**		**,3**	**0**	**3**	**3 0**

. these hours have been passed to the PSNI for viewing as the Trust is unable to view these on the system

Historic Investigation

Overall Incident Totals

Total incidents identified	1369	100
Total incidents completed	1068	
Total outstanding Still to be reviewed	**3**	**23**

NB. This relates to the total number of incidents identified by both PSNI and the Trust from across all Wards as detailed below.

Patient Safety -

High risk context nationally/internationally a high prevalence of abuse of people with a learning disability

Detection and Prevention of Abuse of Adults with ID and Other Developmental Disabilities in Services A Systematic Review Collins and Murphy, 2020

Not to be accepting of abuse, but to recognise the need for continued vigilance in Muckamore and indeed in any care setting where people with a learning disability live together

Review sets out risk factors for abuse and protection factors against abuse :

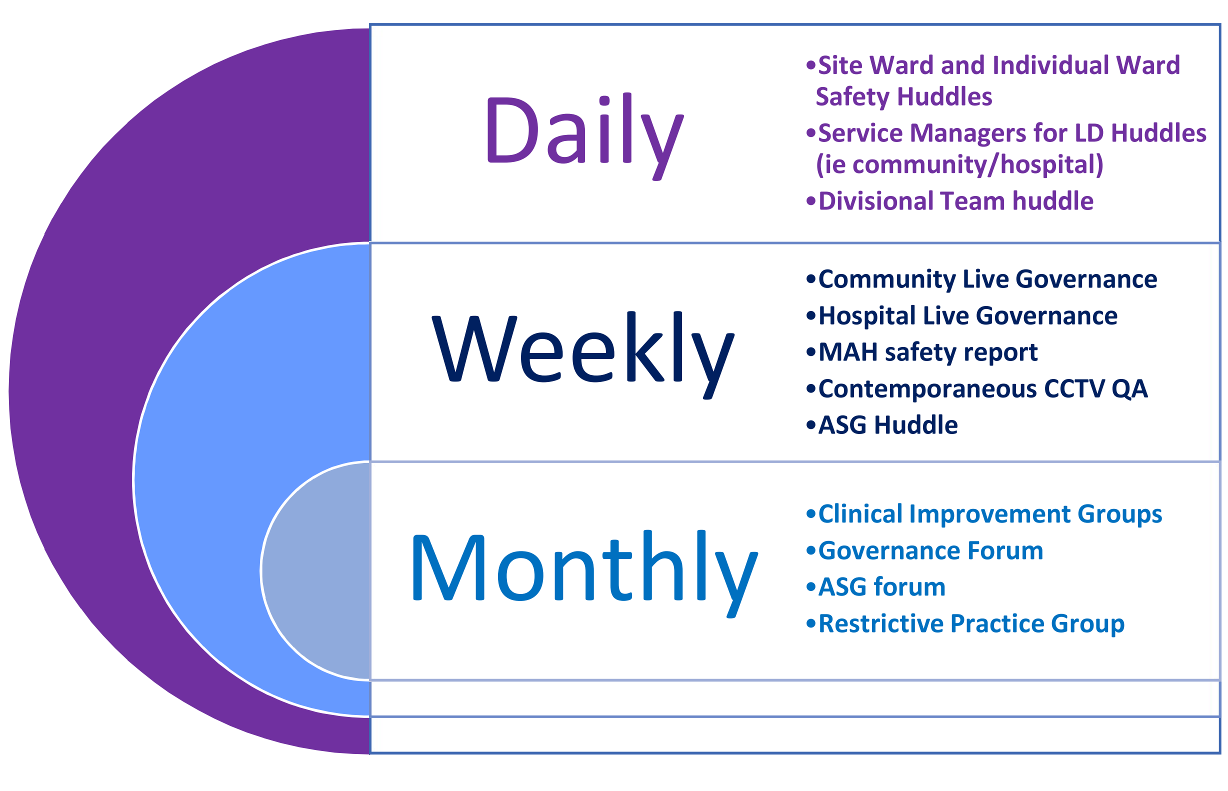
- *'it is unsurprising that the risk factors for abuse have largely remained consistent over the last 30 years'*

While a number of risk factors have been addressed or mitigated against, a number remain, for example, complexity of case mix, communal living, environment, temporary nature of workforce/turnover

Patient Safety - 2

- Stable Leadership and majority of managerial posts now filled
- Commitment to Family Involvement and enhancing Advocacy
- CCTV in communal areas and contemporaneous CCTV report outs
- Ward to Trust Board Safety Reporting
- Quality Management System
- Weekly Safety Report
  - Adult safeguarding activity and thematic review
  - Incidents and complaints
  - Physical Intervention
  - Restraint and Holds
  - Chemical Restraint
  - Seclusion and Voluntary Confinement
- Positive Behaviour Support Team
- Therapeutic Day Services and Opportunities
- RQIA Inspection

Patient Safety - 3



Health, Wellbeing and Morale of Staff

Impact of historic investigation continue to be staff progressing to suspension or protection planning

Negative external narrative about Muckamore no differentiation

Loss of confidence of families impacts on staff

Impending prosecutions and Public In uiry

Low threshold for ASG and PSNI involvement

Highest number of incidents involve injury to staff

Staff experience their own trauma

High levels of scrutiny and staff feeling under cloud of suspicion

Families

Families of patients who were in Muckamore Abbey Hospital before the installation of CCTV

Families of former and current patients who are known to have suffered abuse

Families of current patients who were on site during the timeframe of the historic abuse investigation but not in areas with CCTV

Families of patients who have been admitted since the timeframe of the historic abuse investigation

Families – Historic Investigation

The Historic ASG Team supports 34 families

Good system of FLO support - works well

All affected families have a bespoke Support Plan

We need multi-agency buy in to creating time for briefing families ahead of any announcements otherwise BHSCT on back foot and credibility is eroded

Families of those who have been abused are being re-traumatised, eg.PPS announcement

New group of families emerging via PCC

Families of Patients in Muckamore

Risks and Challenges

- Loss of trust and confidence with some families
- Risk of not seeing or hearing the positive feedback
- Many staff who families knew and trusted have gone
- Families uestion their ability to trust staff based on past experiences
- Adult safeguarding incidents when they occur on site create doubt and uncertainty
- Prosecutions and Public In uiry may undo any ground which has been gained

Actions

- Enhanced Advocacy (PCC)
- Muckamore Carer s Forum
- Trust Board LD Champion
- Community LD Forum
- Muckamore Newsletters
- Carer Questionnaire
- Carer Commitment
- Recruitment of PPI Lead
- Review of Advocacy Services
- Post lockdown we want to renew our efforts to create a sense of community around the site

Workforce – 3 Areas of Risk

- Nursing
- Adult Safeguarding
- Medical
    - Consultant Psychiatrist
    - Leadership

Nursing Workforce -

Current hospital model, majority of care delivered by nursing staff working as part of wider MDT alongside medical, AHP, psychology and social work staff

Recruitment and retention remains challenging

Nursing workforce model now well established and in operation across the site

- **of nursing workforce comprised of substantive BHSCT staff**
- **2 of registrants working on site are substantive BHSCT staff**
- **3 of non-registrants working on site are substantive BHSCT staff**

5 of registrants on site are RNMH

12-month Service Level Agreement with Direct Health Care - 50wte registrants on a block booked basis

Rolling recruitment - 10wte Senior Nursing Assistants (Band 3) have joined since end Jan 2021 and there were 3 successful candidates at the Band 5 interviews in Dec 2020. These candidates are nursing students candidates and will take up post in Summer 2021.

There are a further 15 Band 5 candidates to be interviewed and 24 Band 3 candidates to be interviewed following the most recent advertisement.

Three permanent appointments have been made at Band 6 level with a further advertisement for additional posts.

In the last month, 2 registrants have handed in their notice one for a position closer to home, and one for a developmental role in forensic services (NHSCT)

Nursing Workforce – position at 0 2

Ward	Nursing Model wte	BHSCT Staff Available wte	Reg	Non Reg	Agency Block booking	Reg	Non Reg	Other Backfill Bank/ Add hours/OT	Reg	Non Reg	Variance after Backfill	% Achieved against plan
CF1	37.15	15.76	4.8	10.96	12.98	7.26	5.72	3.96	0.38	3.58	-4.45	**88.03**
CF2	34.72	16.34	3.85	12.49	7.45	7.45	0	5.57	2.3	3.27	-5.36	**84.56**
Ardmore	31.17	23.37	4.28	19.09	5.9	5.9	0	3.79	1.14	2.65	1.89	**106.05**
Sixmile	31.92	9.35	3.4	5.95	20.29	15.16	5.13	3.22	1.08	2.14	0.94	**102.94**
Erne	46.67	16.9	2.8	14.1	25.32	13.57	11.75	3.46	0.5	2.96	-0.99	**97.89**
Total	**181.63**	**81.72**	**19.13**	**62.59**	**71.94**	**49.34**	**22.6**	**20**	**5.4**	**14.6**	**-7.97**	95.61

NUMBER OF STAFF PLACED ON PRECAUTIONARY SUSPENSION		*STAFF WHO CURRENTLY HOLD SUBSTANTIVE POSTS IN MAH*	
70		**43**	
Registrants	Non-Registrants	Registrants	Non-Registrants
34	**36**	18	25 (INCL. 3 X DCW)
NUMBER OF STAFF PLACED ON SUPERVISION		***STAFF WHO CURRENTLY HOLD SUBSTANTIVE POSTS IN MAH***	
60		**30**	
Registrants	Non-Registrants	Registrants	Non-Registrants
32	**28**	14	16 (INCL. 2 X DCW)

Medical Staffing

Medical Workforce

2.5 wte Consultant Psychiatrists in MAH

1.0 wte via agency   no speciality training - indicating will leave as Covid-19 restrictions on travel lift

Single handed (0.5wte) Forensic Consultant

1wte substantive Consultant   no speciality training

Medical Leadership

Vacant Clinical Director and Chair of Division

Exploratory discussions with RCPsych re external assistance /leadership input on sessional basis

Adult Safeguarding Workforce - DAPO and IO Roles

Challenges

- Recruitment and retention rates are poor
- Staff vacancies DAPO and IO
- Increasing re uirement for data analysis and thematic review falling to same team
- Increasing historic workload coming out of engagement with families about the Public In uiry can expect this trend to continue
- Low referral threshold for Adult Safeguarding impacts on caseload volumes
- Complex and time intensive referrals, for example, CCTV viewing to identify if or when an incident occurred in context of allegation with limited detail as to time and place
- Additional site and ward based meetings to maintain communication
- Impact on timeliness of investigations and feedback to families and staff

Actions

- Action Plan in place
- Some posts have been filled through internal expression of interests however no backfill secured
- Permanent recruitment is underway
- Additional training, support and mentoring of staff
- Weekly ASG huddles, weekly ASG meetings in Muckamore and monthly ASG Forum
- Database in place
- Need to ringfence work associated with service delivery today to maintain confidence of families and timely investigations for staff involved in delivering care
- Review of funded workforce has identified need for additional investment to bolster this service inclusive of data analytics support

Resettlement

Rate of resettlement significantly slowed in 2020 due to Covid-19

Lack of community infrastructure continues to be limiting factor for all Trusts and majority of complex patients are being discharged to non-statutory providers of supported housing and nursing care

Success rate of resettlement of patients from Muckamore

2019/20 success rate (n 23)

2020/21 100 success rate (n 5)

Established a BHSCT Resettlement Team

BHSCT Review of Failed Resettlements and Action Plan

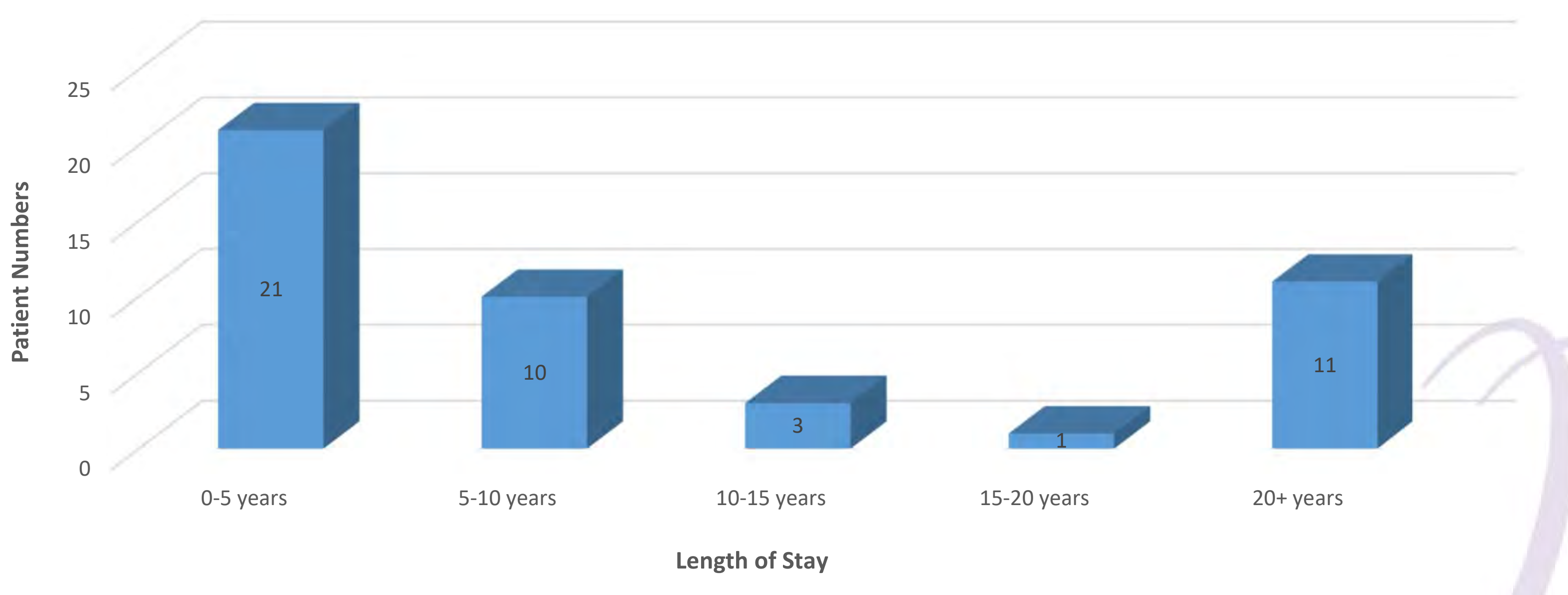
Trust of Residence	Number of Inpatients	Number of Patients on Trial Resettlement
Northern HSC Trust	19	1
Belfast HSC Trust	14	2
South Eastern HSC Trust	8	0
Southern HSC Trust	1	0
Western HSC Trust	0	1
Total	**42**	**4**

The final resettlement patients are highly complex and are likely to re uire a different and more bespoke environment

Ordinary lives re uire extraordinary supports

A Way to Go, SAI Report 2018

Muckamore Abbey Hospital
Length of Stay of Inpatients at April 202



There are 7 patients who have been in Muckamore for over 30 years. The patient with the longest length of stay has been in Muckamore for 45 years.

BHSCT Resettlement Plans

Placement	No	Status	Time frame	Risks
Mallusk		Finalising assessments	Aug 2021	None identified
Bradley		In-Reach (x1)	June 2021	None identified
Mews 2		Two assessments completed Two assessments to be completed	2023	Outline business case being completed. Property to be identified and secured to include planning permission, building and operational readiness. Timeframe dependent on financial approval and no further delays.
CherryHill		Assessment completed	June 2021	Resettlement at an advanced stage however, temporarily halted due to family s re uest for CCTV to be installed in CherryHill.
Knockcairn Extension Forensic	3	Three assessments to be completed	2023	Full business case being completed. Due submission June 2021. Property to be identified and secured to include planning permission, building and operational readiness. Timeframe dependent on financial approval and no further delays.
No Definitive Plans		No definitive plans		Bespoke option or MAH long term option

Admissions and Discharges 20 / to 2020/2

140
120
100
80
60
40
20
0

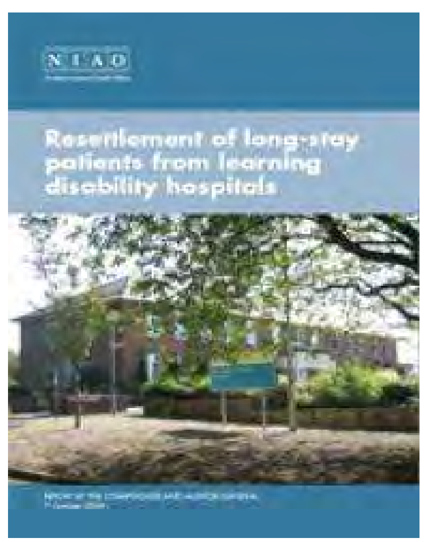
16-17 17-18 18-19 19-20 20-21

106 116 23 6
99 106 44 9 0
99 89 66 52 46

Discharges Admissions Inpatients

NI Audit Office Report 200
Resettlement of Long Stay Patients from Learning Disability Hospitals

'All 3 policy strands - resettlement, short term assessment and treatment and community provision - *must be developed and resourced simultaneously if the overall policy objective of resettlement of long stay patients is to be achieved.'*



Building the Right Support – NHS England 20

‘Challenge is as much about preventing new admissions and providing alternative care and support, as it is about discharging those individuals currently in hospital.’

Pathway redesign for:

- People with a **mental health** problem which may result in them displaying behaviours that challenge
- People who display **self-injurious or aggressive behaviour, not related to severe mental ill-health.** Often a severe learning disability
- People who display risky behaviours which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour)
- People who display behaviours which may lead to contact with the **criminal justice system – often those with lower support needs from disadvantaged backgrounds.**

Resettlement programme for:

- People who have been **in inpatient care for a very long period of time,** having not been discharged when NHS campuses or long-stay hospitals were closed

East London Feedback – Aug 20

Extract of Relevant Recommendations

Develop **robust and responsive multi-disciplinary community services** to mitigate reliance on inpatient services

Increase the accountability and uality assurance of providers supporting people with a learning disability with complex behaviours. This can be achieved by closer liaison and contract monitoring of providers by commissioners and community teams.

Specialist admissions due to complex / challenging behaviours should be a last resort and only agreed by an admissions panel and emergency/direct admissions to specialist hospitals should not be permitted

Enable access to mainstream service provisions, such as crisis teams or inpatient services if risks warrant this

Our Triumvirate Approach

Enhancements to Resettlement Team

Improved processes of assessment, family engagement and in-reach

Strengthened and refined an early escalation approach to maximise admission avoidance CTR process now in use

Develop Community Treatment and Intensive Support Services Consultant Psychiatrist post being advertised

Work to Do

Enhance respite and other community support options for our patients, families and our staff

Provider Development partnership working and performance management test out new finance support role within the LD/finance team

Population based approach to accommodation planning 5 years / 10 years

No Admission Pathway for Service sers with Moderate/Severe LD – BHSCT, SEHSCT and NHSCT

Last admission to Muckamore was December 2019

Challenging and unstable staffing situation coupled with slow resettlement - closed to admission

Last 16 months have demonstrated that service users with a mild LD and some with a moderate LD can be appropriately cared for in MH settings

June to Oct 2021 snapshot - 14 considered for admission

- 8 service users admitted to Adult Mental Health Services
- 5 service users supported to remain in the community
- 1 service user admitted to Lakeview

Risks and Opportunities

- Some service users with moderate, and those with a severe LD, re uire assessment and treatment in a specialist LD unit
- Muckamore does not have the expertise it once did however the teams have demonstrated that they can care for some of the most challenging patients
- Restoration of this pathway could present an opportunity for the site but could also represent a threat
- The creation of this pathway in another Trust could present an opportunity but could also represent a threat

How we do we achieve an assessment and treatment pathway for service users with a severe learning disability in the short to medium term, pending the development of ***a Regional Model of Care***

Model of Care – Short/Medium

Following the closure of our last 2 Covid-19 outbreaks on site, we have brought MDTs together to review patient placement.

The aim is to address inappropriate placement of some patients (eg. 2 non forensic patients in our forensic ward) and continued use of older estate which is not an optimum ward environment

Set of proposed patient moves now to be shared and talked through with families

Through achieving these moves, we also wish to create 1 or 2 ward environments with a focus on caring for long stay patients who could more easily transition to supported living or residential care as an interim next step

We need to assess the viability of doing this on an interim basis without significant capital works and consider new staffing model as wrap around

Model of Care – Long Term

Options appraisal for future role of Muckamore as permanent home for long stay patients

Completed in tandem with focussed family engagement to test assumptions

Assessment and Treatment

Forensic Services

End

Muckamore Abbey Hospital

Stakeholder Summit

29 April 2021

Attendance

Cathy Jack	BHSCT	Chris Hagan	BHSCT
Brenda Creaney	BHSCT	Carol Diffin	BHSCT
Gillian Traub	BHSCT	Emer Hopkins	RQIA
Lynn Long	RQIA	Sean Holland	DOH
Charlotte McArdle	DOH	Mark Lee	DOH
Maire Redmond	DOH	Siobhan Rogan	DOH
Rodney Morton	PHA	Brendan Whittle	HSCB
Briege Quinn	HSCB	Seamus McGoran	SEHSCT
Margaret O'Kane	SEHSCT	Jennifer Welsh	NHSCT
Petra Corr	NHSCT	Seamus O'Reilly	NHSCT

Apologies

Tony Stevens, RQIA

Introduction

Cathy opened by describing the history of the hospital - Muckamore Abbey Hospital was established in 1949 as a regional hospital for children and adults with an intellectual disability. At its peak there were over 1,400 patients in the Hospital. In the 1980s, a policy was introduced to reprofile services towards a community model and resettlement was prioritised. There was slow progress, and the policy was re-stated in both Bamford and Transforming Your Care with a target that all patients would be resettled by 2015. This target has been repeatedly missed.

Today there are 42 inpatients in the hospital with 4 patients out on trial resettlement. Only one patient is on active treatment for their mental health.

CCTV footage between March and September 2017 found previous unreported and widespread abuse of patients which understandably has caused significant undermining of trust and confidence in the ability of the Trust to provide safe and compassionate care.

The staffing situation on site is 50% agency nursing. There are 70 staff who are suspended and we have approx. 60 staff on protection plans (supervision and training).

Our ask today is to hear the views of all our stakeholder organisations in order that we can triangulate and make sense of the system within which we are working and to identify and share openly our gaps and risks. I as Chief Executive want and need to ensure that the Trust is doing all it should and could to provide safe and compassionate care within the resources we have available to us.

The stark reality is that we are providing treatment to only one patient in the hospital which means we have 41 patients who are being cared for in the wrong place and by the wrong team – that is our biggest risk – we need to resettle our patients for their betterment.

BHSCT - Presentation by Gillian Traub, Carol Diffin and Brenda Creaney – slides enclosed

SEHSCT – Presentation by Margaret O'Kane – slides enclosed

Use of Mental Health Beds for People with a Learning Disability

Sean noted that there is a policy direction from Bamford for patients with a mild /moderate learning disability to be admitted for assessment/treatment in mental health facilities and it is not correct to say that the use of MH beds is prima facie a bad thing. Seamus responded that the concern is that this change occurred without any consideration of the capacity required and any investment needed. The determination of the capacity mental health services need did not take cognisance of any demand from LD and the context is of continuing bed pressures in mental health facilities across NI. Emer added that RQIA are in the middle of a review of the experience of mental health services in the context of bed pressures, which includes the impact on the care and treatment of people with a learning disability who are in mental health facilities.

NHSCT – Presentation by Petra Corr – slides enclosed

PHA

Rodney noted that there will be investment in 2021/22 of 25 wte new nursing posts – including Nurse Consultant and Advanced Nursing Leads for each Trust – a welcome opportunity to create a model of career development to enhance retention.

HSCB

Brendan discussed the work that has been completed on the contingency plan in the event of a sudden closure of Muckamore, precipitated by a staffing crisis. These plans are to address our collective risk of this scenario unfolding.

Other key risks from HSCB perspective include:

a. Availability of Inpatient Beds – concern re the lack of access to inpatient beds. NHSCT proposal under consideration to open a 3 bedded LD unit in Holywell.
b. Service Model – HSCB will be bring forward a public consultation this year on the future model
c. Potential for Delays in Resettlement Plans – HSCB will continue to support and monitor the plans of all Trusts and we are supporting work on a dynamic framework contract for accommodation to deliver bespoke options for complex cases
d. On Site Accommodation – can this achieve betterment for some patients

Brendan added that there are no magic bullets to address the situation; the issue and risks are shared and known. Cathy said it is important that there are no surprises for any organisation in this high risk situation.

RQIA

EH noted that RQIA have completed a high number of inspections in the last 2 years – five multi-disciplinary full team inspections and two supplementary. These have provided additional assurances. The risk that RQIA is carrying is that as a result RQIA have not been able to visit all of the other mental health facilities. There are 2 full time RQIA inspectors for Muckamore Abbey Hospital assurance and monitoring which is not sustainable.

During the last couple of inspections, RQIA have been impressed with the quality of care being provided, despite all the risks described. There will always be a risk of poor care but we are not seeing poor care when we visit – we are seeing effective and compassionate care. There has been an increase in adult safeguarding referrals but we see this is a positive increased recognition with staff being

proactive. We do not believe that this represents a deteriorating position and we feel it is only fair that we congratulate the Trust on what is has achieved in the last 2 years.

DOH

Charlotte noted that the Delivering Care money this year will support the development of a career pathway for learning disability nursing which has been eroded over the years and to ensure that students and new nurses have senior posts they can aspire to. The fact that there are only 19 registrants with permanent contracts is a significant risk.

Charlotte added that it is also necessary to invest in the wider multi-disciplinary team – to put them back into the service and build them up – OT, SALT, Psychology, PBS etc.

Sean reflected that in the presentations the risks may have been articulated slightly differently but they are fundamentally the same. The reality is that there will be failures of care again and when there are, the perception from the public will be that nothing has changed and the view will be that 'we are right back to where we were'.

The risks are – wrong model of care, poor care and sustaining care. These are the fundamentals. How do we respond to those risks? Sean outlined a number of responses:

a. A regional service model – designed and resourced with intention
b. Good community support and infrastructure

How do we attract staff – staff do not want to work in Muckamore, it is a toxic brand and there are prosecutions and a public inquiry yet to come. There is little chance for the brand to be rehabilitated but we do still need to invest in Muckamore although we need to be open about the challenge with the brand, and secure pathways for assessment and treatment in the meantime. There are two options – to reopen the doors of Muckamore or to open beds in NHSCT.

In terms of the future, the option to co-locate forensic services in Knockbracken must be considered, and there needs to be an in house resettlement option for when the market does not or cannot respond to the demands.

Cathy asked whether there were any other steps which the Department felt that the Trust should be taking. Sean felt that the focus that has been given to Muckamore by the Trust should be recognised and said that the rest will be slow – it is accepted that Belfast is managing the risks on a day-to-day basis. Sean said he was seeing the collective approach in use increasingly, and that there are discussions happening with a thoughtfulness between Trusts that he would not have experienced before. It is being managed as well as it can and the risks are collectively recognised.

Cathy thanked Sean for his comments, which were helpful and acknowledged the Trust's intention to move forensic services closer to Shannon and for further alignment internally between mental health and learning disability services. The feedback from Sean that there is no quick fix is a welcome one, and that we will all have to manage the risks from day to day.

Sean added that the clinical skills of those trained in LD are needed as well as those for mental health; there is also a prevalence with autism. It is hard to disaggregate LD and MH at times. The principle is that our services should be built on inclusion – when you need a response you get the service that other citizens receive. If your needs are mental health, Bamford said you access mental health services. We need small bespoke units for LD with support from MH reaching in.

Lynn commented on the need to move away from a medical/hospital model towards a social care staffing model. Rodney added that it is more a biopsychosocial model – health care, social care, psychosocial care – all elements are needed.

All agreed that there is a need to change the perception /focus away from hospital care.

Cathy commented on the lack of medical leadership that BHSCT has in this area, and suggested a regional/network is required for LD for the region with a medical lead. Sean said there are benefits to regionality, shared experiences etc but a population health based approach is needed, rather than a medical model. Charlotte suggested that it would not necessarily need to be a medical lead as the model is not only for those with acute care needs. Cathy agreed it should be an MDT network. Emer noted that RQIA have ring-fenced resources for Psychiatry Consultant sessions which have an improvement remit and could support an Improvement Network for LD - she said she would follow up with Cathy separately in relation to whether further support could be given to the Trust.

Brendan described the work of the LD Improvement Board, which is only in its infancy and has the potential to offer a regional approach – so we would not want to replicate/duplicate what already exists. All agreed that the idea of a network required further consideration.

Cathy reiterated her thanks to everyone for the welcome discussion, and for the input from all organisation to the honest dialogue.

**From the Permanent Secretary
and HSC Chief Executive**

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Our ref: RP5957
SSUB-0498-2021

Date: 6 December 2021

Cathy Jack
Chief Executive
Belfast HSC Trust

Sharon Gallagher
Chief Executive
Health and Social Care Board

Dear Cathy and Sharon

I am writing to you to highlight my growing concern about the high level of risk associated with the ongoing operation of Muckamore Abbey Hospital. This, coupled with the failure to develop a robust and workable regional contingency plan, should Muckamore no longer be considered a safe environment for patient care, means that I am not satisfied that, in my role as Chief Executive of the HSC I can provide the Minister with the necessary assurance he needs over the operation of the hospital.

You will understand I am not taking this approach lightly but I consider that it is of the utmost importance that we meet urgently to discuss issues relation to the stability and overall governance of Muckamore Abbey Hospital. I will ask my secretary to contact you to arrange a suitable date so that we can work together to agree a way forward.

Yours sincerely

RICHARD PENGELLY

Working for a Healthier People

Chief Executive
Dr Cathy Jack

Chairman
Mr Peter McNaney, CBE

Your Ref: RP5718
SCORR-0273-2020

10 December 2021

SENT BY EMAIL ONLY

richard.pengelly@health-ni.gov.uk

Mr Richard Pengelly
Accounting Officer
Department of Health
Castle Buildings
Upper Newtownards Road
Belfast
BT4 3SQ

Dear Richard

Thank you for your letter of 6 December 2021 highlighting your growing concerns about the high level of risk associated with the ongoing operations of Muckamore Abbey Hospital (MAH) and the lack of a robust and workable regional contingency plan. I share your concerns.

Muckamore Abbey Hospital has been and continues to be a critical risk area for the Trust. You may be aware that 7 months ago on 29 April 2021 I held a stakeholder summit because of the ongoing and real risk for the safety of this service and this meeting was attended by key stakeholder's organisations including the DoH, HSCB, RQIA, PHA and all other Trusts except the Western Trust. My colleagues and I, in the Trust, have been very transparent and explicit about the ongoing risks that we carry. At that meeting, it was made clear that MAH had only 1 patient on active treatment and 41 patients who no longer required hospital care and should be resettled but because of a lack of appropriate community resources could not.

At the April meeting Sean Holland acknowledged that MAH was the wrong model of care and the sustainability of the model was at risk. He advised a regional service model with good community support and infrastructure, was required. He acknowledged that staff do not want to work in MAH – that MAH was seen "as a toxic brand" even before the prosecutions and the public Inquiry.

Sean, when asked, what more the Belfast Trust could do, replied that the focus given to MAH by the Trust should be recognised and accepted. He acknowledged that MAH was being managed as well as it could and that the risks are collectively recognised across the system.

Brendan Whittle, HSCB commented that there was no magic bullet to address the situation; the issues and risks are shared and known. Everyone at the summit acknowledged the risk situation which Belfast Trust has been actively managing for several years. The MAH continues to cause serious concerns for myself, the Directors and the Board of the Belfast Trust.

I enclose for information the minutes from the Risk Summit.

Since the Risk Summit (7 months ago) there has only been two Departmental Assurance Meetings (chaired by CNO and CSW) in June and August with the October meeting being cancelled. However, the Trust continues to submit weekly nursing staff returns to DoH colleagues – Siobhan Rogan and Maire Redmond so that everyone is fully sighted on the ongoing nurse staffing risks.

In April 2021 the nurse staffing in MAH was at 40% trust own staff and this has now reduced to 33% (22 November 2021). Whilst we do have good agency support everyone would acknowledge that this is not a stable long term solution. Our core nursing staff complement is expected to worsen over the next 2 - 3 months as staff leave for promotion or a post in the new Learning Disability facilities opening in other Trusts.

In July – August, RQIA did a further unannounced inspection and concluded that good systems were in place for ASG and highlighted an extra cautious approach (which is understandable given the context). They also commented on the sustainability of the site and the significant staff shortages with an increasing number of existing nursing staff on protection plans.

Despite the above we continue to be put under pressure to admit more patients, given our tenuous staffing levels. On the 23 August 2021 Brendan Whittle wrote to me requesting two patients were admitted to MAH within a few days as the unit in England where they were residing was closing and there was no space in other LD units in Northern Ireland. I replied the same day making clear my view about the ongoing risks and tenuous position of MAH. I declined to admit the two patients explaining that with ongoing challenges and vulnerabilities around safe staffing I could not accept these patients given the significant risk to the other 41 patients in MAH. I made clear that without robust regional contingency this would be an exceptionally high risk strategy and requested that if the HSCB decided to pursue this then the DoH and Minister should be fully informed and support this. Fortunately, the two patient's placements were subsequently placed in other hospitals with better staffing levels.

Furthermore, since then we have been placed in an invidious position to take two detained patients from the community in October 2021. Legally detained patients must be admitted and there were no other beds available in NI. This was only possible due to a small number of patients being on trial of resettlement. However, before accepting these patients the Trust under the leadership of Moira Kearney called a multiagency meeting with the DoH / HSCB as no other Trust or Mental Health facility had any

capacity. That is the stark reality of the situation that the system currently faces around the Learning disability services and inpatient facilities.

Then more recently in November 2021 we were again put under pressure to accept a patient from the Department of Justice but could not accommodate the patient due to staffing issues.

Currently there are 41 inpatients in MAH with 1 under assessment and 1 under active treatment. We have 4 patients on trial of resettlement and 39 who no longer require an inpatient bed. Of these 39 patients, whose discharge is delayed, their residential address is from across NI - 18 Northern Trust, 12 are Belfast Trust, 8 South Eastern Trust and 1 Southern Trust.

Since September 2020, 8 patients have been successfully discharged into the community (Belfast Trust 5, Northern Trust 2 and Western Trust 1). There are a further two patients that have just commenced trail resettlement in December 2021.

The resettlement of patients must be accelerated as given the ongoing PSNI arrests, potential prosecutions and the public inquiry getting underway the ability to safely staff MAH will became ever more challenging and precarious.

As of November 2021 there are a total of 83 staff on precautionary suspension, 41 of these hold substantive posts MAH. Of the 41, 15 are registrants and 26 are non-registrants. In addition there are a total 62 staff placed on supervision and training. 32 of these hold substantive posts in MAH of which 13 are registrants and 19 are non-registrants.

A further letter updating you on the actions of the Trust in relation to Leadership & Governance Review recommendations will follow in the near future.

I really welcome the meeting next week with yourself and Sharon so that we collectively can safely manage the risks of this key service, which cares some of our most vulnerable patients, going forward. Given what happened in MAH and the harm caused that is the very least that we can do.

I believe this needs a whole system solution.

Yours sincerely

Dr Cathy Jack
Chief Executive

Enc

CC: Sharon Gallagher

Chief Executive
Dr Cathy Jack

Chairman
Mr Peter McNaney, CBE

Your Ref: RP5718
SCORR-0273-2020

20 December 2021

SENT BY EMAIL ONLY

richard.pengelly@health-ni.gov.uk

Mr Richard Pengelly
Accounting Officer
Department of Health
Castle Buildings
Upper Newtownards Road
Belfast
BT4 3SQ

Dear Richard

I am writing further to my letter of 10 December 2021 and your previous letter of 29 March 2021 regarding the Muckamore Abbey Hospital Leadership and Governance Review. In your letter you have raised a number of points which I will address in turn.

1. Outcome of Referral to the GMC

I have previously shared with you the correspondence from the GMC who have advised that they are awaiting the outcome of the PSNI investigation and the Public Inquiry. There has been no further update.

2. Review of Individual/Team concerns within the Report

This review is ongoing but to date there have been no concerns regarding individuals or teams referenced in the Report which have necessitated escalation.

The Executive Director of Nursing has considered self-referral to the Nursing and Midwifery Council in respect of the criticism about her in the report. She sought advice from the Chief Nursing Officer, (Prof McArdle) and the Royal College of Nursing. The result of these discussions and advice was that a referral was not required. She has completed a professional reflection summarising her learning based on this report.

3. Concerns with the performance of any Non-Executive Director of the Trust Board or the Chair of the Trust Board

In relation to the performance of the Non-Executive Directors and the Chairman, I would advise you that no individual concerns have been identified regarding their performance within the review report. In relation to the accountability of the Chair and regarding Non-Executive Directors, as your letter states they are Ministerial appointments. Accordingly the Chair wrote to the Minister by letter on 25 August 2020 and met the Minister on 23 September 2020 to discuss.

The Minister stated at that meeting that he was content that the Chair and the Non-Executive Directors continue in their positions pending further review when the report of the Public Inquiry becomes available. The Minister further noted the actions being taken by the Trust Board, since it first became aware of the problems in Muckamore, to scrutinize and assure itself of the safety of current operations at the site.

4. Update on the implementation of the Recommendations of the Leadership and Governance Review

There are six recommendations for the Trust in the Leadership and Governance Review Report:

Recommendation 1
The Trust should consider immediate action to implement disciplinary action where appropriate on suspended staff to protect the public purse.

The Trust has engaged 8 independent investigators to undertake the disciplinary investigations. Up to 16 December 2021 the PSNI has provided the Trust with the names of 24 individuals that the Trust may proceed to investigate under the internal disciplinary process. These include both current and former employees that the PSNI has completed interviews and prepared prosecution files for the Public Prosecution Service. Of the 24 individuals, 11 cases have been concluded with decisions to dismiss. (5 of the 11 were former employees). 1 disciplinary hearing took place at the end of October and there are a 7 investigations underway. Of the remaining 5 cases, 1 case is ready for the investigation to commence and the remaining 4 cases are currently being prepared for investigation which involves input from Adult Safeguarding and the identification of incidents from the CCTV footage. The 8 investigators work in pairs and all four teams are all actively engaged in work to progress the cases to disciplinary hearing.

The PSNI has recently provided the Trust with the names of a further 31 individuals that they have advised they are no longer treating as suspects in the investigation. PSNI has confirmed they are content for the Trust to move forward with any disciplinary procedures in relation to these individuals if deemed appropriate and the Trust is reviewing these names to ensure appropriate action is taken.

Recommendation 2
The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.

Muckamore Abbey Hospital is a high risk environment. The Trust convened a Risk Summit earlier this year with all key stakeholders to discuss the risks and challenges in effectively managing the facility and ensuring the safety of patients. I enclose a copy of the BHSCT presentation to attendees at the summit held on 29 April 2021, as well as the minutes. I would highlight the comments of the RQIA who stated "during the last couple of inspections RQIA have been impressed with the quality of the care being provided despite all the risks described". Mr Holland, Chief Social Worker, also stated that Muckamore "is being managed as well as it can be and the risks are collectively recognised". At the most recent RQIA inspection of Muckamore Abbey Hospital in July 2021, RQIA described evidence of safe and compassionate care.

The dedicated Co-Director arrangements for Muckamore Abbey Hospital which were put in place in October 2019 were partially stood down in June 2020 when a permanent Co-Director appointment was made for Learning Disability Services as a whole, i.e. inclusive of the community and hospital services. The dedicated Divisional Nurse post remains, as does, the Divisional Social Worker, Rhoda McBride.

Since this time there has been an improvement in substantive managerial appointments – these have included the Co-Director, Tracy Kennedy, a dedicated Service Manager and two permanent dedicated Assistant Service Managers for the hospital. There has also been excellent progress with substantive appointments at Band 7 and Band 6 Ward Manager and Deputy Ward Manager level. The Chair of Division was advertised but despite interest following a second trawl, no appointment was made. The Clinical Director for Learning Disability is on maternity leave and an interim Clinical Director is in post - Dr Ken Yeow.

Regarding the Director role, I previously wrote to you regarding my desire to secure additional Service Director posts including one which realigns Mental Health and Learning Disability services into one Directorate. This is similar to other Trusts in NI. This new Director role recognises the need to address growing demand and risk in both Mental Health and Learning Disability services, and acknowledging the accepted view that these services should be managed together. This includes Muckamore Abbey Hospital where there is considerable work rebuilding trust between the Trust and our service users and their families. A new model of care needs to be developed for the vast majority of remaining inpatients who no longer need hospital care. Consideration of this issue will be a core part of our corporate prioritisation of reviewing the care of our most vulnerable patients. I am very pleased to advise that Mrs Moira Kearney took up post as our new Interim Director for Mental Health and Learning Disability services on 16 August 2021.

As you are aware these plans will also achieve the decoupling of Children's Community Services from the Executive Director of Social Work (EDSW) role. Freeing up the EDSW role is vital to optimise the identification and management of Adult Safeguarding risks, including the immediate issues in relation to Muckamore Abbey Hospital, and will support the Service Director to ensure that all appropriate safeguards are in place to protect patients. Carol Diffin works closely with Moira Kearney to collectively manage the safeguarding risk.

Recommendation 3
Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

The Trust has a long-standing advocacy contract with Bryson House for patients with a learning disability across hospital and community settings. In the last 18 months, the Patient Client Council has also recruited additional advocates for Muckamore families and they have been heavily involved in respect of the Terms of Reference and subsequent engagement in relation to the impending Public Inquiry.

A number of meetings took place in 2021 with representatives from Families Involved NI to develop draft Terms of Reference for a review of advocacy services. The Terms of Reference were subsequently tabled at the regional LD Improvement Board for agreement with Trusts and HSCB. An independent investigation team comprising two previous HSC Directors with relevant experience have been secured to lead this review - a review initiation meeting took place in October 2021 and this work is now underway.

Recommendation 4
The complaint of Mr. B of 30 August 2017 should be brought to a conclusion by the Trust's Complaints Department.

The Leadership and Governance Review of Muckamore Abbey Hospital recommended the Trust bring to a conclusion the complaint of Mr Brown.

Following the publication of the Leadership and Governance report when Mr Brown's position regarding his unresolved complaint was made known, Miss Traub, Interim Director for Learning Disability Services, spoke to Mr Brown on 28 August 2020 to seek to understand his outstanding concerns. Since this telephone call, there has been significant work undertaken to revisit the points of concern which were raised - these included a number of concerns which had previously been responded to by the former Director for Learning Disability services.

The key outstanding issue of concern for Mr Brown is that his son absconded from Cranfield 2 Ward on a number of occasions on 22 December 2018, which was the day that patients were permanently moved out of PICU Ward in order that it could close. This was precipitated by the sudden and severe reduction in staff on site due to a high number of staff suspensions in a very short period of time. On the day in question, Mr Brown's son left Cranfield 2 Ward intermittently as at that time it was not a locked ward. He was accompanied by staff when he left the ward and returned on each occasion.

When Mr Brown raised concerns at the time that his son had been able to leave Cranfield 2 Ward and go outside, the CCTV footage was downloaded, pixelated and shown to him by his Family Liaison Officer on 8 August 2019. This footage was of events that took place on the morning of 22 December 2018. Mr Brown explained to the FLO when he viewed the footage that staff had told him that his son had been unsettled the entire day, rather than just on the morning, and he therefore requested footage from the afternoon of 22 December.

Unfortunately due to the automated process of overwriting within the CCTV system, by the time of this request being processed, the CCTV footage of the afternoon had been overwritten and therefore not recoverable.

Mr Brown believes that the events involving his son leaving Cranfield 2 ward on 22 December 2018 constitute a Serious Adverse Incident. Miss Traub agreed to source the CCTV footage of the morning in order that this could be independently viewed and the question asked anew - did the experience of Mr Brown's son constitute an SAI. Unfortunately when Miss Traub sought access to the footage, she was advised that the downloaded and pixelated footage had been deleted by Radio Contact in 2019, with the permission of a (since retired) member of the management team. This means that there is no CCTV footage available to be viewed. This was new information to the current management team and Miss Traub alerted Mr Brown to this in a letter of 26 February 2021.

Miss Traub wrote to Mr Brown to propose that the Trust proceed with an independently chaired Significant Event Audit to examine the events of 22 December 2018 and to identify learning. This audit would also consider whether the criteria of a Serious Adverse Incident had been met. Mr Brown indicated that he is seeking legal advice.

Mr Nigel Barr, Ferguson & Co, responded on 22 October 2021 with further queries in relation to the complaints response and request for further information in relation to the issues raised. At this time the Trust is considering referring the complaint to the Northern Ireland Public Services Ombudsman (the Ombudsman). In order for this to proceed, Ms Kearney has written to Mr Brown on 17 December 2021 to advise of this and seek consent from Mr Brown for the Trust to make this referral to the Ombudsman.

Recommendation 5
In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

A CCTV Working Group was established in December 2019 to oversee issues associated with CCTV on site. Unfortunately this Group was stood down during Covid-19 but has recently been reinstated. Prior to being stood down, the CCTV Working Group prioritised and completed the following developments:

- Additional training/support and discussion with CCTV reviewers (contemporaneous viewing)
- Clarification and refinement of CCTV viewing template for contemporaneous CCTV viewers
- Introduction of a QA step with management and safeguarding representatives to review the contemporaneous CCTV viewing feedback and identify immediate actions
- Engagement with Trade Unions (ongoing) re staff concerns with remit of CCTV contemporaneous viewing

The management team are supportive of the option to use CCTV to inform training and best practice developments and discussions around the use of CCTV footage as part of MAPA training have already taken place.

Due to the significant concern on site of any widening of the role of CCTV on site, the CCTV Working Group devised questionnaires to seek views on a range of potential uses of CCTV footage. Questionnaires were sent out to families and for staff and a separate feedback session with patients in Sixmile was also conducted with TILII. Since the return of these questionnaires, senior management on site have held open meetings with staff to discuss in more detail the proposals for expanded use of CCTV, in particular the use of footage of physical interventions which demonstrate good practice. It is proposed to carry out an incident debrief with the use of CCTV footage as a pilot.

Recommendation 6
The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

The Leadership and Governance Review looked outside learning disability services and examined how the organisation was structured, how it operated and how Directors, Executive Team and Trust Board shared and acted upon information about Muckamore. The Review Team considered a wide range of issues under the broad umbrella of accountability in their report, including but not limited to

- The extent to which the Hospital featured at Trust Board and Executive Team meetings
- The curiosity of the Trust Board and senior leaders
- The level of reporting at various levels of the organisation
- The form and function of Delegated Statutory Functions reports
- Leadership Visibility
- Culture

The autonomy of Directors and the requirement to hold them to account, as described in the Recommendation, is one small part of the accountability framework that is in place and evolving with the Trust. As Chief Executive I am responsible for holding Directors to account for achievement against their objectives, which are set on an annual basis and subject to regular review. Directorate and Divisional Management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a developing quality management system (QMS) which provides a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system facilitates the Trust Board to provide ongoing challenge throughout the year, rather than being responsive to issues escalated to it. The Trust Board Assurance Framework is also being refreshed to reflect this QMS approach as the basis of the Trust's accountability and assurance processes. From January 2022 every Director has to produce an assurance map of services they are responsible for indicating the evidence they use to provide assurance.

Each Division now has a basic QMS data set but further refinement over the next year is required and is ongoing. Furthermore, the Medical Director is developing an accreditation service at the local Service Manager and Clinical Director level which will ensure demonstration of quality at the individual, team, divisional and directorate level.

The Quality Management System will:

- Enable Directors and Divisional Teams to develop management information which makes sense of their business in a consistent, integrated framework;
- Integrate assessments of safety, outcomes, efficiency, access, patient and staff experience under the banner of quality;
- Ensure better management of risk in real time, with earlier detection and prompt remedial action
- Instil confidence from our ability to provide reliable and transparent assurance to Trust Board, DOH, HSCB, our partners and public on the effectiveness of our decision-making and progress to meeting priorities
- Continue to satisfy our reporting responsibilities to DOH, HSCB and other stakeholders

The service wide overview of safety and quality within the QMS system will ensure that all services across the organisation are formally reviewing and reporting on these metrics regularly and as part of a system. This system exists alongside daily safety huddles which take place across all levels of the organisation inquiring and responding to live issues. In addition to these formal arrangements for reporting, Muckamore has shaped the organisation by bringing a renewed focus on the responsibility on all leaders to create the structures, forums and culture in which openness and transparency about problems is encouraged and supported - and which encourage all leaders throughout the organisation to stay curious.

Furthermore, a new collective process of sense making involving Executive Directors for Social Work, Medicine and Nursing with one or more Service Directors, has been introduced. Although in its infancy, early feedback from teams is that it can enhance the quality and depth of enquiry and problem solving around complex issues.

In March 2021, a detailed report came to Trust Board which sought to answer the question 'What's Different in Muckamore?' This was the first formal product of this collective sense making process. An extract from this paper is enclosed which sets out some reflections on the future direction for Muckamore, and indeed learning disability services as a whole.

There is regular 'Ward to Board' reporting on a range of safety metrics relating to Muckamore, which monitor the use of restrictive practices across seclusion, voluntary confinement, chemical restraint, physical restraint and physical intervention as well as the number and nature of adult safeguarding incidents involving patient-patient incidents and staff-patient incidents.

The Early Alert system and the Serious Adverse Investigation protocol are both utilised when the respective definitions are met and Significant Event Audit methodology is used across the site following incidents where there is opportunity for learning. Trust Board receives a report every month on Muckamore Abbey Hospital which includes the metrics describe above, but which also includes progress on the historic investigation and the disciplinary processes. More recently the Trust Board reports have also included updates on strategic developments including discussions on regional developments as well as the future service model for the site.

Safety parameters demonstrate a significantly different and improved picture across these aspects of safety compared to the historic CCTV footage which showed frequent use of seclusion, overuse of PRN medication and high levels of physical restraint often not in keeping with MAPA principles.

RQIA's most recent inspections – the inspections in December 2019, October 2020, January 2021 and July 2021 have provided assurance that the Regulator is satisfied that care is safe today. This view was also expressed by RQIA at the Stakeholder Summit.

The Adult Safeguarding Committee and the Social Care Committee are two groups which are also extending their reach and their teeth under the leadership of the Executive Director for Social Work. For example, under the auspices of the Adult Safeguarding Committee the Trust is completing a self-assessment exercise to identify services for vulnerable people who are carrying a number of risk factors which if left unchecked could result in poor quality of care and experience of care, as well as issues with service continuity. It is an early attempt at developing and applying a risk-based approach across all care settings to create the opportunities for early intervention and preventative measures.

The Leadership and Governance Review identified a lost opportunity to identify and address issues in Muckamore Abbey Hospital through Delegated Statutory Function reports, both within the organisation and by those organisations across HSC who received and responded to the reports. The Social Care Committee has increased its focus, and that of Trust Board, on these Delegated Statutory Function reports and there is a greater understanding of the significance of these reports, enhanced scrutiny on areas of compliance and non-compliance, and follow up by way of action plans.

In 2020, the Trust Board asked Mrs Anne O'Reilly, Non-Executive Director, to take on a new role as the Trust's Learning Disability Champion – this appointment came at the request of families who have lost faith in the Trust as a carer and advocate for those with a learning disability and their families. The purpose of this appointment is to ensure that relevant discussions and decisions taken by the Trust Board have at their heart the human rights of those with a learning disability. Our aim is also to reaffirm the primacy of family involvement using a number of different approaches and through revitalised and resourced structures for engagement. The review and ultimate strengthening of our advocacy arrangements is also a key aim – as a service we need to embrace opportunities to be challenged, questioned and held to account in the delivery of care to this vulnerable group. The proposed independent review as described above will help us to identify how we can improve our advocacy arrangements and in the interim, the additional advocacy support give to families by the Patient Client Council has already brought a stronger sense of accountability for the Trust.

What happens in Muckamore Abbey Hospital is under constant, intensive scrutiny as part of our regular management arrangements in the Trust and beyond. What happens there is more visible than it was in the past, including to Trust Board. It is safer, it is better understood and we know that there are examples of very compassionate care. However, it remains a high-risk service - it is inherently high risk. When we really stand back, our sense is that as it is currently constructed, Muckamore offers an out-dated service model which is providing care in the wrong place, and at the wrong time and in a number of ways, by the wrong staff. The future in our view is a much pared back hospital service sitting alongside a comprehensive community model, and predominantly a social care model not a nursing model.

Moving towards a new model of care requires very careful and sensitive management of our relationships with patients and their families - first and foremost. It also requires active, informed and persistent regional planning and commissioning and we are fully committed to be active participants and indeed influencers and leaders on behalf of our service users and patients as these plans progress.

I hope that you find this response helpful in updating you in relation to the Trust's response to the findings of the Leadership and Governance Review. If you have any further queries I would be happy to discuss further.

Yours sincerely

Dr Cathy Jack
Chief Executive

Cc Mr Peter McNaney Chairman, Belfast HSC Trust

Enc Minutes of Risk Summit held on 29 April 2021
Extract from 'Whats Different about Muckamore?

APPENDIX 1

Extract from 'Whats Different about Muckamore?

11. The Future

What is different about Muckamore now is the level of uncertainty about its future – concerns abound about its closure even though the extant policy position is that it is not closing. There could be many reasons to close Muckamore – not enough staff which makes it not viable; patients are resettled which means there is no longer the need for such a large inpatient learning disability facility; the loss of public confidence in the service and the brand/name. Undoubtedly recruitment and arguably more so, retention, is hindered by the lack of a clear policy position on the future of Muckamore. The recommendation in the Leadership and Governance Review that consideration be given to which Trust is best placed to lead the service has only compounded the situation, adding a further layer of uncertainty.

A 'vision' for Muckamore cannot be described without considering the whole landscape of learning disability services. There is a continuum of need with an Assessment and Treatment Unit, ie. a hospital admission, the last option for a very small number of people who need it after all other options have been exhausted. We cannot design a service for this small group without understanding and designing the whole.

There have been a number of documents produced. The first is the 'We Matter' paper which is the Adult Learning Disability Service Model for Northern Ireland. This paper describes the need for each Trust to have its own acute inpatient assessment and treatment service as well as an enhanced community based assessment and treatment option, what we described earlier as intensive treatment support. This paper also sets out a shift away from a facility such as Muckamore which provides beds for 3 Trusts, to a model where each Trust has its own inpatient beds.

The second document is the draft Strategic and Commissioning Plan for Learning Disability Services 2021 – 2024 produced by HSCB. This sets out a number of practical priority areas for development – this is a more granular paper which draws in a number of recommendations from 'A Way to Go' and the Muckamore Abbey Hospital Leadership and Governance Review. With input from all five Trusts there is the potential that this can act as an operational roadmap for us all.

Neither 'We Matter' nor the Commissioning Plan describe what the future looks like in terms of the scale of the inpatient provision required, and in practice there is not currently a consensus among BHSCT, NHSCT and SEHSCT that each Trust could support its own inpatient unit. There is also a continuing debate about the number of beds actually required. Separate HSCB and tri-partite Trust discussions are ongoing and HSCB have indicated earlier I n2021 that they will progress a needs assessment to inform a consultation paper on the future model (shape and size) of inpatient services for Northern Ireland. Some simple questions need answered, for example, how many inpatient learning disability beds does a population of 1.8 million need. The completion of a needs assessment is welcome.

The DOH were undoubtedly responding to feedback they had received from families when the DOH wrote to all Trusts urging caution about a 'resettlement at all costs' approach. This further evolved with a letter from the Chief Social Worker asking the Trust to consider an option to allow a small number of our patients who have lived the majority of their adult life in Muckamore to be resettled permanently on site. An initial scoping by all three Trusts has identified a small number of patients who may meet this very basic definition. This is something different for Muckamore, an opportunity to design a new future. However, there is concern that if all families are made aware that there is a facility being developed on site or adjacent to Muckamore, some may choose to withdraw from resettlement plans which are already advanced.

For Muckamore, there is also the issue of Sixmile Ward, an inpatient low secure forensic ward for patients with a learning disability. There will always be a requirement for this type of ward, albeit analysis of new admissions and delayed discharges would indicate that the number of beds required is very small. The ward currently only has male patients– there is no provision for females, and there is also no medium secure provision for patients with a learning disability in Northern Ireland. If patients require medium secure provision then they have to go to another part of the UK. The Mental Health and Learning Disability Forensic Network is likely to have a pivotal role in navigating these issues.

Describing a vision for Muckamore is to have a vision for its component parts, and to place it in a continuum of care, from community services, through to intensive treatment team, and an inpatient Assessment and Treatment Unit. In trying to describe a vision, we arrive at options – options which need teased out, challenged and discussed with our partners in health and social care and our families and carers. We have an opportunity to be bold in our vision but we should not seek to do this alone – much like this co-produced set of reflections, a vision for learning disability services and the future of Muckamore should be tackled collectively.

Independent Review of the Learning Disability Resettlement Programme In Northern Ireland

Bria Mongan & Ian Sutherland

July 2022

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Acknowledgements

The review team completed significant engagement and received considerable documentary evidence from a wide range of stakeholders and wish to acknowledge and thank those who so kindly shared their expertise.

The review team would like to thank all those who gave so generously of their time to meet with them and contribute to the review most especially the individuals and family carers who have lived experience of resettlement. The richness of their advice and experience has informed our findings and recommendations.

Learning disability care providers from across the voluntary and independent sectors shared their knowledge as system experts with the review team.

The review team benefited from a site visit to MAH and valued the opportunity to meet with patients and ward staff

The directors in each of the HSC Trusts and their senior management teams actively engaged and supported the work of the review team providing documentary evidence and assisted in the identification of the barriers and challenges that need to be addressed to expedite resettlement.

Staff from DoH, SPPG /HSCB also provided considerable documentary evidence, advice and support.

The HSCB/SPPG provided technical and secretarial support and the review team would particularly wish to thank Patricia Elliott for her technical expertise in the production of the report and Caroline McGonigle for her support throughout the fact finding process of the review.

1. Executive Summary

1.1 In October 2021 the Health and Social Care Board (HSCB) commissioned two experienced senior leaders in health and social care to undertake an independent review of the learning disability resettlement programme in Northern Ireland, with a particular focus on the resettlement from Muckamore Abbey Hospital (MAH), which is a specialist learning disability hospital managed by the Belfast Health and Social Care Trust (BHSCT) but located outside Antrim.

1.2 The purpose of the review built on a stated intention from Department of Health and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and overarching vision, as well as barriers, and to develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

1.3 There is a strong legislative base and policy framework, although the policy and strategy relating to services for people with learning disabilities/ASD and their families is in urgent need of updating, and this is currently being reviewed. An overarching vision for learning disability services in the 2020's would allow stakeholders to agree a Learning Disability Service Model, which would guide commissioners and providers towards the development of better integrated, community orientated services which will deliver stronger outcomes for people with learning disability and their families. This policy will need to consolidate the outstanding ambition that no-one will live in a specialist learning disability hospital and that hospital will focus on its primary function of offering assessment and treatment only for those people for whom this cannot be made available within a community setting.

1.4 Leadership and governance with regard to the resettlement programme in Northern Ireland has been less than adequate. Progress and momentum to deliver homes outside of hospital for the remaining cohort has been slow. There were a number of confounding factors that impacted directly on progress. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle ovid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, there has been an extended period of

significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. in order to strengthen the focus on system wide performance management. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it does not satisfactorily explain why some Trusts made negligible progress, but for others consistent stepped change was achieved.

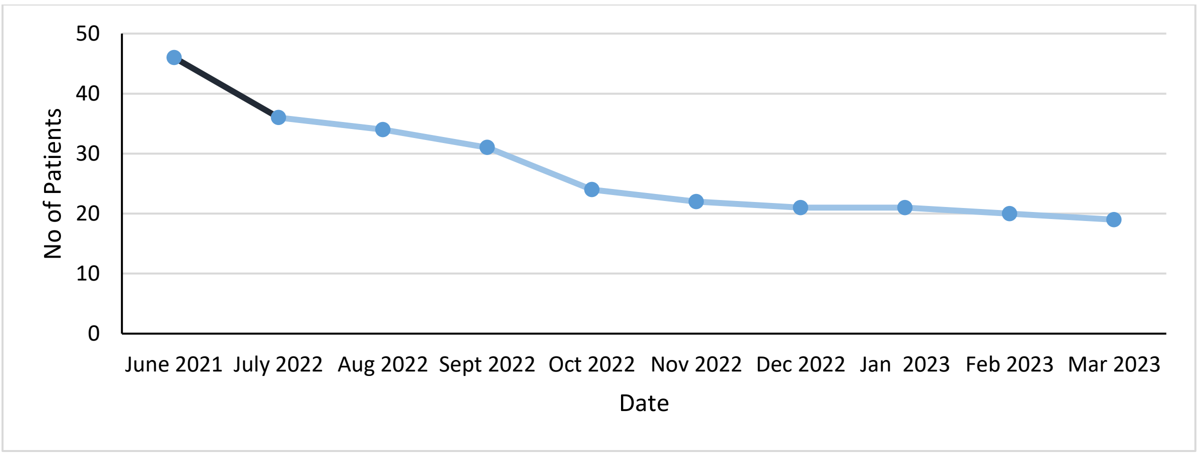
1.5 The BHSCT which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis management of MAH. The Trust Board were reassured by the executives that there were plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust. Arrangements in BHSCT were further hampered by significant changes in the leadership team for LD services. Other Trusts responsible for resettlement of patients from MAH had made more progress in the development of new services, although the delivery had been slower than hoped with delays relating to building over-runs and recruitment difficulties. The HSCB had made efforts to support regional co-ordination of the resettlement programme, but these were not effective in delivery of a well-co-ordinated programme plan. In particular the HSCB was not good enough in terms of performance management of the resettlement programme which amounted to little more than performance monitoring. We saw some strong leadership by individuals both in the statutory and non-statutory sectors, and whilst the rhetoric was of a robust commitment to collaboration there was little evidence of strong partnership working. In terms of leadership around the delivery of schemes in most cases management grip was weak and this contributed significantly to drift and delay. The voices of people who required resettlement and their families were not well heard within this process and they did not feel that they were empowered or engaged in the process at all levels. Opportunities to learn from their expertise by experience were missed.

1.6 Strategic commissioning and inter-agency working were supported by a clear and explicit strategic priority being identified around resettlement and workforce development in the 2019/20 commissioning plan. The Northern HSC Trust and South Eastern HSC Trust had response plans that were proactive and generally well progressed, but the BHSCT plans failed to progress beyond the preliminary stages. The lack of either effective programme or project management meant there was no over-arching, costed plan. Trusts were planning in relative isolation and communication of joint arrangements was inadequate. Generally there was

a tendency by Trusts to initiate new developments without fully exploring whether there was some existing provision within the market that could meet some of the identified need, even if this required some re-design or re-purposing of provision. The new build options, whilst being bespoke, were generally costly in terms of capital and revenue, and resulted in long lead in time to delivery. There was limited evidence of senior engagement with the independent social care sector as strategic partners as well as providers, and therefore market shaping was not evident.

1.7 The review team looked at the approach being taken to individualised care planning. There was a lack of consistency in the documentation used to support care planning for transition from hospital to community, and nor was there an agreed regional pathway for resettlement, which should map out roles and responsibilities within the process. Families and providers both commented that they felt only involved in a limited way in developing assessments and care plans. Of the remaining patients awaiting discharge almost a quarter had been in MAH for more than 20 years and one person for more than 40 years. About a third of this group had also had one or two previous trials in community placements, although there was little evidence of how lessons were learnt from these unsuccessful moves. However, in the 12 months from June 2021 to June 2022 the population in MAH awaiting resettlement had reduced by 20%, and the trajectory of future resettlements by NHSCT and SEHSCT should mean that between September 2022 and March 2023 the population will reduce by a further approximately 50%, leaving around 19 people in MAH awaiting resettlement.

1.8 Whilst progress at the beginning of the review had been slow HSC Trusts have recently reviewed their approach to consider alternative options that have potential for more timely discharge. The review team were pleased to see that this has improved the resettlement trajectory which anticipates that the population will reduce to between 15 and 19 by the end of March, 2023.



1.9 A key element of the review was the operational delivery of provision to meet the needs of this cohort and the wider LD population. There is an impressive range of provision across registered care and supported living settings providing approximately 2,500 places for people with LD in the community. There was a tendency of commissioners and resettlement teams to not engage with providers to consider potential existing opportunities, although this has changed in recent months. The overall trend within supported living schemes is to smaller size provision, with the largest number of schemes offering 3 places. The biggest single issue and risk facing the range and quality of the provision was workforce, and the DoH are now sponsoring work regionally to try to address this challenge which will report in 2023. The quality of care within the independent sector is regulated and inspected by RQIA, and the overall quality is good. There is some very innovative practice emerging within the independent sector, with a strong commitment to the use of Positive Behaviour Support (PBS) models, with some examples of transformational care being provided to individuals in their own new homes. Where provision was strongest there was a strong partnership between providers and local HSC Trust commissioning/care management and clinical services, so that individuals had access to a wide range of highly responsive services.

1.10 The Trust's commissioning of schemes of registered care provision to meet their respective resettlement cohorts was variable. The NHSCT and SEHSCT demonstrated a more proactive and consistent approach to planning of this provision, and consequently have reached a stage where 2 substantial new care settings, along with some smaller scale provision will over the next 6 months provide new homes to approx. 80% of their remaining MAH residents. The BHSCT have over the last 3 years been scoping 3 potential new schemes, but these have never got beyond the most preliminary stages of planning. The review team are more encouraged that the new leadership group responsible for LD within that Trust are now considering other options, including some existing provision which could have the potential to be rapidly re-purposed. In general, and at variance with statements that the Trusts have a learning culture, there has been little rigorous evaluation of the successes and failures within the resettlement programme. The review team heard a rich tapestry of stories from families about their lived experience, and this should form the basis of some qualitative work, but in addition there should be some review of the clinical and social benefits derived by people who have gone through resettlement.

1.11 For families, safeguarding continues to be an abiding concern, which is overshadowed by a loss of trust and confidence in MAH and health and social care systems more generally. The oversight of adult safeguarding will be strengthened when the new adult safeguarding arrangements come in to place, and it is encouraging that an Interim Adult Protection Board (IAPB) was established in 2021. There continue to be issues of concern in relation to the use of physical intervention, and surveillance by CCTV, and for the families the review team met, how these are addressed in community settings is central to the success of placements. There is a need for further consultation with

individuals, families and providers to inform regional policies on these important areas moving forward. Family members were clear with the review team that after community placement they would continue to play a key role in assuring and ensuring the safety of their relative, and therefore wanted to see open and flexible access to care environments. Care providers were clear about safeguarding responsibilities but expressed a concern that they experienced considerable variation in the application of thresholds in relation to investigation of safeguarding concerns, and families expressed concern that in some situations investigations were not progressed in a timely fashion.

1.12 Families were an incredibly rich source of evidence to the review team, and their lived experience tells a tale of both success and failure. The full report includes aspects of these accounts. The review team strongly believe that individual families need to be at the centre of these processes and fully engaged within all aspects of the resettlement, but they also need to be able to influence policy and strategy so that their expertise by experience can inform best practice. The review team were struck by the extent to which trauma and distress featured within the experience that was shared, and that all of the professionals working with these individuals and families need a good understanding of trauma informed practice. Trusts were all considering and developing their advocacy and other supports for individuals and families, and they need to further consider how they can put in place opportunities to ensure better communication and engagement and opportunities to organise carer support events such as group gatherings.

2. Terms of Reference

2.1 Terms of Reference: The terms of reference for the review were agreed with the HSCB and DoH, after consultation with senior leaders in learning disability services from the 5 HSC Trusts.

2.2 Purpose of Review: The purpose of the review built on a stated intention from DoH and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH (MAH) and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and barriers and develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

2.3 The review team were to work collaboratively with stakeholders, with the commitment of the Chief Executives and the Directors, engaging appropriately with relevant staff, agencies, families and service users.

2.4 Timescale: The timetable for the work was to take place over a 6 month period which began in effect in November 2021.

2.5 The Review Team were required to give particular consideration of the current care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. In addition they were asked to look specifically at the following areas:-

- Length of time patient has been in MAH and where they were admitted from
- Ascertain if resettlement has already been trialled
- Summarise the policy and practice evidence base in relation to resettlement programmes.
- Identify those individuals where plans are absent or weak in relation to their resettlement
- Work with leaders in the appropriate Trusts to ensure that suitable resettlement plans are developed.
- Critically evaluate the progress of resettlement plans as devised by the responsible Trust for the identified individuals.
- Business cases which have been completed or are still in process identifying any positive outcomes and any strategic or operational barriers. Make recommendations for actions that would strengthen or accelerate the delivery of proposed pipeline schemes.

- Review to what extent the engagement strategies employed individually by Trusts, and collectively by the system as a whole have been effective in supporting the delivery of the MAH resettlement programme.

2.6 Inter-Agency Working : The review team were asked to consider whether/how the agencies and professionals involved in resettlement of patients, have worked effectively with each other at each and every stage of the process.

2.7 Parental/Carer Engagement/Advocacy: The review team were also asked to consider as a critical factor whether and to what extent the families of the patients were engaged in decision making around resettlement. In this context the review team were also asked to explore whether and to what extent, independent advocacy and support was provided.

2.8 Outside of Scope: Whilst there are Issues relating to children and young people with learning disability/Autism who may be subject to delayed discharge in other settings, this population were not included within the terms of reference for this review.

3. Methodology

3.1 The HSCB in appointing the review team intended to ensure that an objective, critical appraisal was undertaken of the existing programme of resettlement for individuals with learning disability/autistic spectrum disorder with a primary focus on the remaining population of people who were awaiting discharge from MAH to new homes.

3.2 The review team decided to adopt an approach for the review based on 'appreciative inquiry' (1) this is a strengths-based positive approach to leadership development and organisational change. This approach seeks to engage stakeholders in self-determined change, and incorporates the principle of co-production.

3.3 By adopting this approach the review team were both 'observers' of the system and how it was delivering the required outcomes for people identified for resettlement, but also as 'agents' by helping to seek solutions that would assist key stakeholders to improve the resettlement programme in Northern Ireland.

3.4 The review team adopted the following methods to progress the key lines of inquiry:

- Direct observation and participation in key processes
- Direct interviews with a wide range of stakeholders
- Gathering and analysing data relevant to the resettlement process
- Focus groups – both face and face and digital engagement.

3.5 The initial engagement with the statutory health and social care agencies was through the leadership meetings established by the HSCB to develop and oversee the delivery of effective services for people with a learning disability/ASD. This included the Learning Disability Leadership Group comprising the senior social care leaders from the HSCB, the 5 Trust Directors of Mental Health and Learning Disability Services, along with representation from the DoH and RQIA. Additionally the review team participated in a range of operational and strategic meetings with programme leads for learning disability services within the HSCB and HSC Trusts. Some of these processes were inter-agency and included NIHE representation.

3.6 The review team sought data and documentary evidence from a wide range of organisations including the DoH, HSCB, the 5 HSC Trusts, NIHE, RQIA and other agencies. Information was sought through direct requests and through questionnaire response.

3.7 The review team held an extensive range of engagement sessions with a range of external stakeholders. This included the following:

- Northern Ireland Housing Executive - NIHE
- Regulation and Quality Improvement Authority – RQIA
- Northern Ireland Social Care Council – NISCC
- Patient and Client Council – PCC
- Royal College of Psychiatrists – NI/Learning Disability Division - RCPsych
- ARC Northern Ireland
- Independent Health Care Providers [NI) – IHCP

3.8 The review team felt it was of primary importance that the lived experience of individuals with learning disability/ASD and their carers/families who had been engaged in resettlement had to be well represented within the review. They met with individuals and groups of carers who had either been through or were still going through the resettlement process. This provided some of the richest detail of how the system was working, or not working, for people who wanted to have the opportunity to live in a setting outside of hospital with as much independence as possible.

4. Legislative, Strategic and Policy Context.

In this section we will critically evaluate the legislation and strategic policy across England, Scotland, Wales and the Republic of Ireland to identify models of good practice in reducing delayed discharge patients and preventing hospital admission.

4.1 MAH opened as a regional learning disability hospital in 1949 and by 1984 the in-patient population had grown to 1,428.

4.2 The scale of resettlement between 2007 and 2020 was significant, with reduction in the population at MAH to 46 patients by June 2021. During the period of this review, the Muckamore Abbey population has reduced further to 36 in-patients by July 2022. It is encouraging that further discharges have been achieved however, 10 of the delayed discharge population are from the original Priority Target List (PTL), which relates to patients living in a long stay learning disability hospital for more than a year at 1st of April, 2007, and have been discharge delayed between 16 and 45 years. The impact of institutionalisation for a small number of long-stay patients has been a barrier in transitioning to the community. The complexity of need and range of co-morbidities of recent admissions many of whom have been impacted by previous community placement breakdown, has made discharge particularly challenging. However, the review team visited community resettlement schemes successfully supporting individuals with very complex needs equivalent to the needs of those people delayed in discharge. These examples of good practice highlight that the models of care and support required to build sustainable community placements for individuals with complex needs are already operational in Northern Ireland and the success factors need to be scaled up and embedded in commissioning and procurement processes.

4.3 The pace of progress in relation to finding new homes in recent years has been disappointing, with an increasing number of judicial reviews progressed by patients or their family carers in regards to the failure of HSC Trusts to commission an appropriate community placement for people delayed in hospital. Legal judgements have highlighted that delayed discharge breaches are incompatible with obligations pursuant to section 6 of the Human Rights Act 1998. (Ctrl Click) and Article 8 of the European Convention on Human Rights (Ctrl Click)There is therefore an ethical, strategic and legal imperative to complete resettlement.

4.4 The policy direction in Northern Ireland and Great Britain changed in the 1980's and from that time there have been a series of targets set to reduce the number of in-patients in Learning Disability hospitals and develop resettlement options.

However, targets and deadlines for achieving this have been missed, ignored and repeatedly reset.

4.5 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy,' Health and Wellbeing into the New Millennium'[1] established a commitment to reduce the number of people admitted to traditional specialist hospitals and a commitment that care should be provided in the community and not in specialist hospital environments. In 1995, a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the 3 learning disability hospitals in Northern Ireland. The target set by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.

4.6 The 2002 Bamford Review of Mental Health and Learning Disabilities represents the key strategic driver shaping delivery of services for individuals with learning disabilities and or Autistic Spectrum Disorder (ASD) over the past 25 years.

4.7 The second report from the Bamford review 'Equal Lives' published in 2005 sets out a compelling vision for developing services and support for adults and children with a learning disability. Equal Lives concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve developing responses that are person centred and individually tailored; ensuring that people have greater choice and more control over their life; that services become more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important; increased flexibility in how resources are used; balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

4.8 The Bamford review 'Equal Lives' published in 2005 (ctrl click) included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. A priority target list (PTL) of those patients living in a long stay learning disability hospital for more than a year at 1st April 2007 was established to enable monitoring of progress on the commitment to resettlement of long-stay patients. In 2005, the Hospital had 318 patients and a target was set to reduce to 87 patients by 2011.

[1] *Health and personal social services: a regional strategy for Northern Ireland 1992-1997.*

4.9 'Transforming Your Care' was published by the Minister for Health in 2011(ctrl click) which further strengthened the commitment to close long stay institutions and complete resettlement by 2015. A draft Strategic Implementation Plan was developed to drive forward the recommendations in terms of learning disabilities with a focus on resettlement, delayed discharge, access to respite for carers, individualised budgets, day opportunities , advocacy and Directly Enhanced Services (DES) Whilst this resulted in the development of additional community services the resettlement target was again missed.

4.10 DHSSPS Service Frameworks aimed to set out clear standards of health and social care that service users and their carers can expect. They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process. The Service Framework for Learning Disability was initially launched in 2013 and revised in January 2015 (ctrl click). It sets out 34 standards in relation to the following key thematic areas; safeguarding and communication; involvement in the planning and delivery of services; children and young people; entering adulthood; inclusion in community life; meeting physical and mental health needs; meeting complex physical and mental health needs; a home in the community; ageing well and palliative and end of life care. The standards provide guidance to the sector on how to: improve the health and wellbeing of people with a learning disability, their carers and families, promote social inclusion, reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society.

4.11 RQIA Review of Adult Learning Disability Community Services Phase II October 2016 (ctrl click) reviewed progress made by the 5 Health and Social Care (HSC) Trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework. The review found that none of the 5 community learning disability teams in HSC Trusts demonstrated an evidence base for the model of service configuration they have put in place. The RQIA review concluded that community services have developed more as a result of historic custom and practice in each Trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The RQIA review found that there is no agreed uniform model for behavioural support services across the 5 Trusts.

4.12 This review team noted that these findings still apply. Community services are at different stages of development in each of the 5 HSC Trusts and the terminology used to describe similar services varied across HSC Trusts which makes it

difficult to compare and contrast services. It is still of concern that there is no agreed model for behavioural support services. Each Trust and care provider organisation have adopted differing accredited programmes with training programmes available only on licence which limits the portability of staff working flexibly across HSC Trusts and the independent sectors. It is of note that consideration was given by a HSC Trust to deploy Trust staff to supplement the care provider workforce to expedite a resettlement however, the barrier to this innovation was that the staff in the Trust and staff in the provider organisation had been trained in different therapeutic interventions and could not work in the same team unless re-trained. It is critical that standardisation of positive behaviour approaches and therapeutic intervention methodologies is considered to maximise collaboration and enable mutual aid at times of crisis.

4.13 'Systems, Not Structures – Changing Health and Social Care' (The Bengoa Report) (DoH, 2016) (ctrl click) Guided by 'The Triple Aim': to improve the patient experience of care (including quality and satisfaction); improve the health of populations and achieve better value by reducing the per capita cost of health care. The report provides a succinct transformation model relevant and useful in the development of the learning disability service model and driving the system towards Accountable Care Systems with the provider sector taking collective responsibility for all health and social care for a given population.

4.14 Health and Wellbeing 2026 – Delivering Together (DoH, 2017) (ctrl click) is the policy response to the Bengoa Report and aligns to Draft Programme for Government with increasing focus on outcomes.

4.15 The emergence in 2017 of allegations of abuse at MAH, resulted in an independent Serious Adverse Incident (SAI) review of safeguarding practices between 2012 and 2017 at MAH. The SAI report exposed not only significant failings in the care provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities.

4.16 The final 'Way to Go' report (ctrl click) was shared with key stakeholders in December 2018 and a summary of the report was published in February 2019. This resulted in a further public commitment to the families of MAH patients by the DoH Permanent Secretary in 2018 that patients delayed in discharge would be resettled by December 2019. This commitment has not been met.

4.17 The DoH established a Muckamore Departmental Assurance Group (MDAG) to provide assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The DoH

recognised the need for the HSC system to work together in a co-ordinated way to deliver a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs. Some of the MDAG actions have not yet been achieved.

4.18 The 'Review of Leadership and Governance at MAH' (ctrl click) was established to build upon the SAI review and the report published in July 2020 highlighted system-wide issues and a failure in the care provided to some of the most vulnerable members of our society. The findings highlighted the need to provide a clear and coordinated regional learning disability pathway similar to that in place for mental health services. HSC Trusts were remitted to carry out a full re-assessment of the needs of their patients in MAH and prepare discharge plans for all those delayed in discharge. The review found that HSC Trusts had not yet completed a full reassessment of all patients and that discharge plans had not been prepared for all patients.

4.19 Many of the findings and recommendations from both the 'Way to Go' report and the 'Review of Leadership and Governance at MAH' (ctrl click) remain relevant and outstanding and will be reiterated in this review. The' Way to Go' report made 2 overarching recommendations; a renewed commitment to enabling people with learning disabilities to have full lives in their families and communities and the development of a Learning Disability strategic framework focused on contraction and closure of the long-stay hospital and a vision for a full lifecycle pathway across children's and adult services. The Leadership and Governance review findings highlight that Discharge of Statutory Function (DSF) reports provided annually by the Trust to the HSC Board, were largely repetitive and did not provide the necessary assurance with insufficient challenge from Trust Board and the HSC Board. This review found that this remains an area of concern and that limited progress has been made in regard to the strengthening of governance to ensure a greater challenge in regard to reporting and accountability arrangements.

4.20 The review team reviewed the strategic policy for Learning Disability services across England, Scotland, Wales and the Republic of Ireland to identify best practice and the learning from actions taken by other regions in regard to learning disability resettlement and avoidance of hospital admission. The review team identified common themes in the strategic direction for Learning Disability services across England and Scotland with focus on hospital avoidance through development of intensive care and support in the community. The following sections provide a high level summary of the key policy and practice evidence which should inform the strategic direction for learning disability services and the resettlement programme in Northern Ireland.

4.21 Despite the evidence base on concern about safety and quality in institutional settings, there has been a lack of progress in the closure of long-stay beds. This issue has been addressed across all jurisdictions over many years and it is important to learn from these experiences and actions. Our review found a striking alignment across all nations in regards to strategic direction with a focus on a Human Rights and person-centred approach. The 2007 Bamford Review of Mental Health and Learning Disabilities has been the key strategic driver shaping the delivery of services for individuals with learning disabilities and/or autism in Northern Ireland. The principles and values underpinning the Bamford review, remain relevant to current policy direction and are in keeping with the strategic direction of other UK nations. Feedback to the review team from a range of stakeholders however, highlighted the effectiveness of the Mental Health strategy in building upon Bamford and the need for refreshed strategic policy for learning disability services.

4.22 The Bamford Review of Mental Health & Learning Disability in 2002 (ctrl click) recommended a comprehensive legislative framework for new mental capacity legislation and reformed mental health legislation for Northern Ireland. The Mental Capacity Act (Northern Ireland) 2016 (ctrl click) has been partially commenced and currently provides a new statutory framework in relation to deprivation of liberty. Part 10 of the MCA will set out the provisions for people in the criminal justice system when enacted. Mental health legislation is complex most especially relating to patients with a forensic history. The review team noted a lack of clarity across the HSC system in regards to patients who have been stepped down from detention in hospital under Art 15 leave. The review team recommends a review of the needs and resettlement plans for all forensic patients.

4.23 There have been a series of high profile scandals following investigations identifying abuse to residents in HSC facilities over the past decade. MAH is the largest adult safeguarding investigation across the UK. On 8th September 2020, the Health Minister announced his intention to establish a Public Inquiry into the allegations of abuse at MAH. The MAH Public Inquiry commenced the hearing sessions of the Inquiry in June 2022 which will run until December 2022

4.24 The Care Quality Commission report (2011) (ctrl click) after inspection of Winterbourne View found a "systemic failure to protect people" Evidence of maltreatment of patients in specialist hospitals in England continued to emerge and eight years later, The Care Quality Commission report on Whorlton Hall (2019) (ctrl click) found people in learning disability hospital being failed and the Care Quality Commission (2019) found evidence of unsafe patient care and abusive treatment by staff at Eldertree Lodge, an in-patient facility for adults with learning disabilities and autism. These scandals have prompted development in strategic policy and a renewed focus on implementation plans to address the

long-standing issue of over-reliance on admission to hospital resulting in delayed discharge and institutionalisation.

4.25 Strategic Policy in England- Building the Right Support: A National Plan NHS England et al (2015) (ctrl click) placed emphasis on the "highly heterogeneous" or diverse characteristics of the population referred to as 'people with a learning disability and/or autism' This challenge has not been sufficiently addressed in learning disability policy in Northern Ireland to date. The majority of people with learning disability live with their families supported if required by a range of community services. The smaller percentage of those with a range of very complex needs requiring coordinated care and support across justice, housing, mental health, and the range of learning disability provider organisations need to be integrated into future strategic policy and commissioning direction.

4.26 There have been a range of reports on the issue of delayed discharge however, there has been a lack of robust and independent evaluation of what has worked well. England, Scotland and Wales are further developed than Northern Ireland in refreshing the approach needed. This review has identified a number of key themes across the revised strategic policy in England and Scotland that should inform revised strategic direction and short and medium term actions required for Northern Ireland.

4.27 'Transforming Care England' – Oct.2015 (ctrl click) - Good practice guidance covers strategic, operational and micro- commissioning and describes what 'Good looks like' with nine Golden threads-core principles. Key actions include;

- Provide enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown.
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response- Target those escalating in need/ at risk of admission-risk stratification.
- Important that experts by experience have been involved in all of the panels. One of the issues has been language – such as database rather than risk register
- Establish a 'Change Fund' from the centre for development of admission avoidance 24/7 intensive support teams
- Positive Behaviour Service framework and provider engagement
- Housing Needs Assessment
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

- Fortnightly meetings on each individual patient with clear projections about the trajectory for discharge and progress over time.
- Specialist LD beds should be increasingly co-located within mainstream hospital settings rather than in isolated stand-alone units.
- The success lies not within systems and processes but within sustainable human relationships and collaboration highlighting the need for system leadership, collaborative working to build a one team approach.

4.28 The NHS 10 Year Plan was published in England in January 2019, and made specific commitments to the improvements to be progressed for people with learning disability and ASD. These included:

- Improve community-based support so that people can lead lives of their choosing in homes not hospitals; further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication through the Stopping The Over-Medication of children and young people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Continue to champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

4.29 'Same as You' (2000) (ctrl click) was the catalyst for Scotland's long-stay closure programme. 'Keys to Life' 10-year Learning Disability Strategy **(**2014) (ctrl click) acknowledged wider system failure in the challenge of expediting discharges and developed a National framework agreement for procurement for specialist residential based care with a focus on the outcomes and rates that will apply. The 'Coming Home' report (2018) commissioned by the Scottish Government (ctrl click) highlighted that a significant number of people remained delayed discharge.

A short life working group was set up to undertake a focused piece of work in relation to complex needs and delayed discharge and published their 'Coming Home Implementation report in February 2022 (Gov.Scot) (ctrl click) . The findings and recommendations are broadly similar to the actions arising from Transforming Care England.

- Engagement with experts by experience and wider stakeholders is critical
- First step is accurate data on Needs Assessment at both population and individual level. Quality of assessments were found to be too generic and quality variable and not sufficiently co-produced with families
- Establish a community living change fund over the next 3 years to be used to design community based solutions running concurrently with disinvestment planning.
- Develop a National Dynamic Support Register to create greater visibility in terms of strategic planning and to allow performance management of admissions to hospital supported by a National panel that can troubleshoot individual cases
- Develop a Positive Behaviour framework-
- Produce a guide to support commissioning and procurement of complex care packages and establish detailed understanding of revenue costs of different care packages. The report highlighted a lack of effective scrutiny of data.

4.30 The Welsh Government published a Learning Disability Action Plan 2022- 2026 in May 2022. The plan builds on and incorporates the Improving Lives Programme (2018) (ctrl click) actions with a focus on reducing admissions through increased community based crisis prevention, access to specialised care and highlights the need to promote Positive Behavioural Support and Trauma Informed care.

4.31 The Irish Government published a national policy 'Time to Move On' 2011 (ctrl click)which sets out the way forward for a new model of support in the community The report highlighted that the model is simple in approach but noted significant challenges to delivery. Integral to the strategy was the 'We Moved On' stories of successful transition and promoting the voice to include advocacy, self-advocacy and family advocacy. The review team met with the HSE National lead who advised that bridging funding through a multi-annual investment plan for 5 year period has been established alongside a value for money and policy review of high cost placements to establish the level of funding per person. Robust Needs assessment was also identified as a priority.

The review team found significant learning from engagement with policy leads in England and ROI which have informed this review and findings.

4.32 Tackling the closure of long-stay beds has been a long standing problem for many decades across all UK nations. Recent strategic policy has recognised that the focus should now be on what is achievable rather than being paralysed by the challenges. There has been growing consensus nationally on solutions and next steps. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts. Adopting an accountable care approach will drive collaboration between HSC Trusts and the range of organisations involved in supporting individuals who are currently 'stranded' in learning disability hospitals.

4.4 Recommendations

- DoH should develop the strategic policy for learning disability services, updating the recommendations arising from the Bamford review to reflect the needs of the highly heterogeneous Learning Disability population and inter-connectedness with the Mental Health and Autism strategies.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on.

5. Leadership & Governance

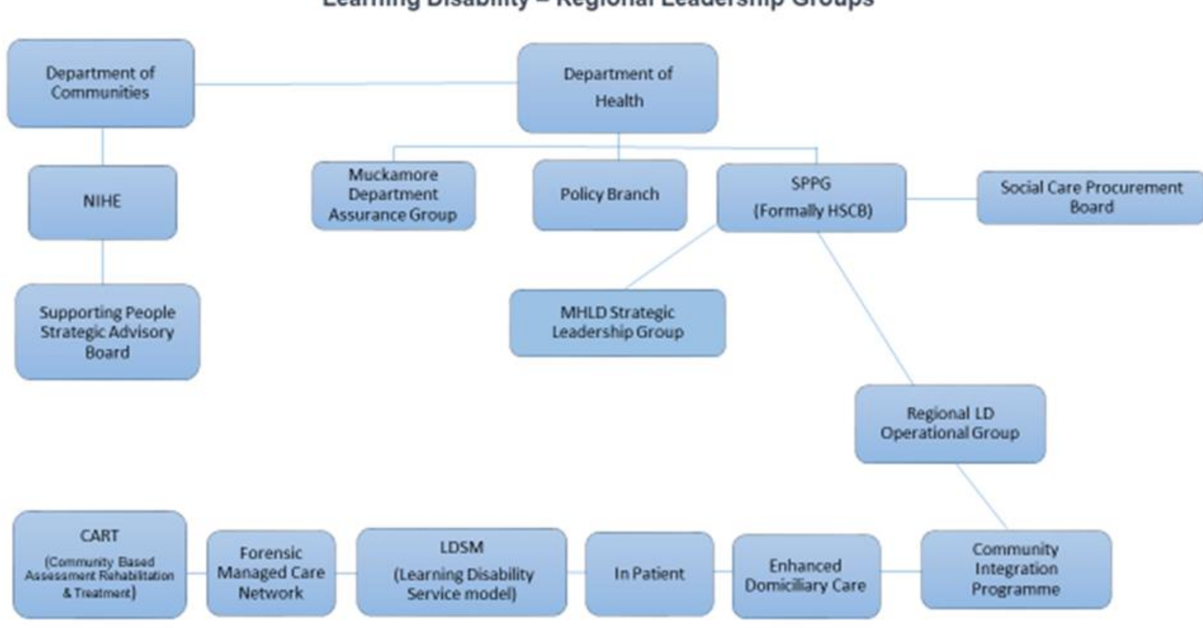
In the last chapter we consider the policy and strategic context for the delivery of the resettlement programme in Northern Ireland, and in this chapter we want to explore how the leaders within Northern Ireland engaged with this challenge.

5.1.1 Within the chapter we will look at how we gathered evidence of leadership and impact, and then go on to consider it under the following areas: strategic leadership and governance; leadership for the operational delivery of resettlement outcomes for individuals awaiting discharge following lengthy periods in hospital; and finally how people who use services and their representatives were engaged in this complex arena.

5.1.2 Evidence Gathered: The review team were pleased that in addition to having access to a raft of documentary evidence that we also had direct access to meet with many of the leaders within the system at all levels, and to observe or participate in key meetings within the leadership framework.

5.1.3 Amongst the documentary evidence that we accessed included strategic and policy documents, Trust Board minutes and Trust Corporate Risk Registers. We also attended the Muckamore Departmental Assurance Group (MDAG) and had access to their more recent action plans and minutes. We also had sight of material related to the Delegated Statutory Functions Reports including the composite reports and action plans.

5.1.4 A very rich area of evidence related to engagement with leaders through direct meetings. This included the Mental Health & Learning Disability Strategic Leadership Group (Directors and other senior officers from HSCB/SPPG & Trust Directors); Regional Learning Disability Operational Group (Trust Assistant Directors and Commissioning & Finance Leads in HSCB/SPPG, along with representation from NIHE and RQIA. We had ‘challenge and support sessions with Trust LD Leadership Teams We have tried to represent the statutory leadership framework diagrammatically – *see below*



5.1.5 The review team were particularly grateful for the extensive and generous sharing of views and experiences from a broad range of stakeholders. Importantly this included parents and carers of people who had direct experience of the resettlement process along with charities that represent them such as Mencap. We also met with leaders from other agencies including housing, provider organisations in the independent sector, regulators for services and the social care workforce, and clinical leadership through the RCPsych. (NI) – Learning Disability Faculty.

5.1.6 An important factor needs to be acknowledged from the outset in considering the leadership challenge in relation to the resettlement programme during recent years, and relates to the context from 2019 to 2022. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle Covid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, during this period there has been an extended period of significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it cannot entirely explain leaders' failure to deliver timely alternatives to residence in MAH in the context of the long term planning in this area. The individuals in MAH didn't

'suddenly' need new homes; there had been a lengthy 'gestation' to this situation, and many opportunities for earlier action.

5.1.7 The review considered leadership in three separate contexts. The first was strategic leadership at the most senior level of the organisations involved, including senior leaders in public service, both executive and non-executive. Strategic leadership focuses on establishing the vision and strategic direction, and ensures effective governance, oversight and scrutiny of delivery of strategic objectives. The second is senior operational leadership to ensure that plans for delivery are robust and achieved, and requires effective partnership working between commissioners, providers – both statutory and non-statutory. The third area that we wanted to consider in relation to effective leadership and governance was the extent to which people at the centre of resettlement, particularly those who were being moved to their new homes and their family members, were engaged and involved in the process, and how effectively they could shape and influence leadership. Central to this is the need to understand leadership at all levels, and how this intersects. What the review team were looking for is sometimes referred to as 'the golden thread, that should weave through all the layers of leadership to ensure that there is a seamless route from strategic vision to effective delivery, and that the best outcomes are delivered in the most efficient and cost effective way, with transformational impact on the lived experience of the people who are being resettled from institutional care to new homes within the community.

5.2 Strategic Leadership & Governance

5.2.1 Strategic leadership and governance has been central to the successes and failures within delivery of the learning disability resettlement programme in Northern Ireland. The policy context since the Bamford Review and before was clear that long stay specialist learning disability hospitals should never be someone's permanent home. Whilst the ambition was clear, and some progress was made, the goal was slow to achieve and by July 2021 46 people remained living in MAH, and more than 5 of these had been in the hospital for between 30 and 45 years. The emerging picture of extensive institutional abuse in MAH in 2018 re-focused attention on the lives of people living in MAH both in terms of the day to day safety of people who were living there, and the need to push harder to find new homes for those remaining individuals within high quality community settings. Whilst this was a significant challenge, it wasn't a new one, and had been a stated health and social policy objective in Northern Ireland since 2005, so it had to be asked why it hadn't yet been achieved.

5.2.2 In order to achieve the significant change required in improving the lives of all people with learning disability and ASD, there was a consistent acknowledgement for the need to update the strategic policy. This was a priority recommendation from the previous Independent Review Panel, which required "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges which is co-produced with self-

advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the hospital and must be accompanied by the development of local services."

5.2.3 The response to this recommendation was that there should be a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This significant task was to be progressed by the HSCB/PHA, and they commissioned a consultation with a wide range of stakeholders which led to the production of a consultation response entitled "We Matter". The final draft of the "We Matter" Learning Disability Service Model was formally presented by the HSCB to officials at the DoH in early October 2021, but to date this has not resulted in the issuing of the long awaited updated strategic framework. It remains important that this work is brought to completion but equally its delay should not have been a reason for a failure on the part of the HSCB and individual HSC Trusts to expedite the resettlement process.

5.2.4 In the next chapter we will explain how in 2019/20, further to a direction from the Permanent Secretary, the regional commissioning framework clearly stated that the resettlement of people from MAH and other LD specialist hospitals remained a strategic priority.

5.2.5 In the context of the significant concerns about MAH the DoH established a Muckamore Departmental Assurance Group (MDAG). The Muckamore Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The Group is jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer, and is made up of representatives from HSC organisations and other key stakeholders, and representatives from families of Muckamore Abbey Hospital patients. It was good to see such a broad constituency, including the families of people living in MAH being brought together. The group undertook considerable work which was organised and monitored through a comprehensive action plan; this was updated and monitored regularly. The plan covered areas such as leadership and governance, safeguarding, resettlement and workforce. In relation to resettlement, after three years of the MDAG operating, all of the actions relating to resettlement continued to be rated as 'red' in relation to delivery. So whilst there was a robust mechanism for holding the system to account and monitoring what had been achieved, in relation to resettlement there was an inertia which represented slow or negligible progress. This led to some considerable frustration across the system, which was evidenced through a number of families launching judicial reviews against health and care organisations to challenge a failure to deliver resettlement

outcomes for their loved ones. Despite a well-articulated call to action there was an absolute lack of urgency and focus in the delivery of the resettlement programme.

5.2.6 Within the MDAG action plan the Director of Social Care and Children (DCSC) was the identified lead for all actions in relation to the delivery of the resettlement programme. In order to deliver this the (DCSC) worked with the Trust Directors through a Mental Health and Learning Disability Strategic Leadership Group. The commissioning plan for 2019/20 was clear about the HSCB/PHA strategic priorities and intentions for resettlement and the required Provider Response (set out in Chapter 6; 6.4.6, 6.4.7, 6.4.8). In order to deliver the required action a number of groups were established to progress at pace the resettlement programme, and further explore this under the next section. However, the DSC & C/HSCB also held a responsibility for ensuring that the individual Trusts were held to account in relation to the delivery of their delegated statutory functions (DSF's), and a specific responsibility for performance management in relation to the delivery of the key strategic targets. Whilst there were fully formalised processes for accountability meetings, with remedial action proposed where performance was weak in relation to the delivery of DSF's, this rarely achieved the significant improvement required. In particular in relation to the resettlement programme, the actions taken by senior officers of the HSCB often represented at best performance monitoring, rather than effective performance management.

5.2.7 Effective performance management relies on the provision of valid data, analysis of performance measures, responsible challenge in relation to under-performance, and effective support to address broader barriers that stand in the face of objective achievement. The absence of fully effective performance management allowed for significant drift in the delivery of strategic priorities which directly impacted on the broader issues relating to the continued concerns around the safety of MAH. There has been significant organisational change since the Minister announced the closure of the HSCB, and the transfer of many of the strategic commissioning and performance management functions have reverted to the Strategic Planning and Performance Group within the Department of Health. We have seen a change in tone and approach in relation in the execution of performance management responsibilities both immediately prior to the transfer to SPPG on the 1.4.22 and subsequently. A number of additional senior appointments have been made within the social care team which should strengthen capacity. In light of these changes the review team are hopeful that the challenge and support function essential to effective performance management will continue to improve.

5.2.8 Belfast Health and Social Care Trust are central to the strategic leadership and governance in relation to the care and treatment of people in MAH, as well as to the resettlement process from the hospital. Their leadership responsibility needs to be set in the context of two important reports commissioned by the

Trust. The first of these was “A Way To Go” (2018) which undertook a review of safeguarding within MAH between 2012 and 2017, which identified extensive evidence of catastrophic failings and found that there was a culture of tolerating harm within MAH. The authors went on to express grave concern that it was “shattering that no-one intervened to halt the harm and take charge”. The CCTV evidence which supported the findings within this report also became central to the subsequent PSNI investigation of allegations against significant numbers of staff within the hospital. The second important report was the Review of Leadership and Governance at Muckamore Abbey Hospital completed in July 2020. This report described the leadership team at MAH as dysfunctional, with a lack of clarity about leadership, and a sense of dis-connectedness with the BHSCT as a whole. The report concluded that the changes in senior management resulted in confusion for front line staff; there was little evidence of practice development and quality improvement in MAH; that there was insufficient challenge from the Trust Board and HSCB in relation to the DSF reporting, and that feedback provided to the Trust from the HSCB related to failings in meeting resettlement targets. The report also reported on limited escalation of key events or concerns to the Trust Board, and also that “The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost: - relatives/carers of patients and hospital staff’s anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients’ transition to care in the community. There was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community” In the final section of the report its’ final recommendation is that, “The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.”

5.2.9 In relation to this recommendation the review team undertook some desk top review of the Trust Board minutes over the preceding year. It was clear that update reports were being brought by the responsible Director in relation to all aspects of the services at MAH. However, we had some concerns about how effective the overview and scrutiny of Trust Board was in relation to certain key elements. In particular there was an acceptance of assurances given that the 16 remaining patients awaiting resettlement from MAH who were the responsibility of the BHSCT had robust plans in place for resettlement. However this was contingent on the proposed service developments which would deliver new homes, and as we will detail in later sections of the report there was no confidence that robust plans were in place for the delivery of such schemes, and that even if in train the earliest date for delivery would have been 2025/2026. In light of this the review team would consider that the Trust Board accepted reassurance from senior leaders, rather than driving for solid assurances which would underpin effective delivery.

5.2.10 One year on from the publication of the Leadership and Governance Review, which recommended that BHSCT consider sustaining the significant number of managerial arrangements instigated following events of 2017 pending the

wider Departmental review of MAH services. The current review team looking at the situation through the lens of resettlement find that there appears to have been only limited progress in relation to the changes that were called for. There continues to be some instability in relation to the leadership arrangements, in that during the last 6 months there have been changes of Director, Co-Director, Lead Social Worker and Lead Nurse; and some of these posts are appointed only on an 'interim basis' implying that they may only be temporary appointments, and with none of the incumbents bringing recent senior operational leadership experience in the field of learning disability. Whilst the review team accept the principle of the transferability of skills and that this is particularly important within senior roles, there is also a need to have a sound understanding of the 'business' particularly in the context of risks and opportunities. However the review team also acknowledge the clear commitment that these newly appointed leaders bring to their responsibilities, which could bring significant opportunity to move on at greater speed.

5.2.11 The review team could see that within BHSCT there had been a real vigour, both by Trust Board and the Executive Team, to address the issues that had emerged as the full extent of the institutional abuse at MAH became clear. This posed them with the linked challenges of rapidly improving the quality and safety of care for the patients within MAH whilst ensuring that there was progress at pace to achieve more resettlement. The review team could see that to some extent the former was contingent on the latter, i.e. that the more quickly the population reduced in the hospital through resettlement the sooner that the issues related to safe staffing levels could be addressed as assuming the staffing establishment was retained and the patient population reduced then the nurse:patient ratio improved accordingly. The review team felt that this balance wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady and consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes. Therefore as will be laid out in subsequent sections the progress of the proposed schemes to be led by BHSCT effectively slowed almost to a standstill, and so other than for a small number of individuals who were able to move to existing provision there were very few people moved. This is in contrast with the NHSCT and SET who have secured new provision which will shortly become fully operational in the next 6 months and consequently a much higher proportion of their clients have plans where there is confidence that they will move in the near future.

5.2.12 BHSCT had a wider responsibility than the other Trusts as they were managing MAH, and had responsibility for the dedicated resettlement teams located at the hospital who had a pivotal role in being the link and liaison with the local teams within the MAH resettlement team had a pivotal role with all 3 Trust community teams including for the BHSCT, NHSCT, and SEHSCT who ultimately would assume responsibility for the clients upon transition to their new homes. However all three of these Trusts had a shared responsibility for the overall

delivery of the resettlement programme. Given the high profile concerns about the safety of MAH, and the linked urgency to find alternative homes for the remaining patients as soon as possible, the review team were concerned that not all Trusts had included resettlement of people with LD/ASD on their Corporate Risk Registers, although in some cases they were on Directorate Risk Registers. Again this may have hampered the ability of Trust Boards to assure themselves that all of the appropriate actions were being progressed to ensure swift actions were being delivered to address the significant risks.

5.3 Leadership in Operational Delivery of the Resettlement Programme

5.3.1 Within the system delivery relies on having senior executive and operational leaders who can take policy and strategy, and ensure that the linked objectives are delivered in practice, and that the outcomes that follow improve the lives of the people with learning disabilities and their families.

5.3.2 Within the HSC system in Northern Ireland this covers a broad range of leaders in senior roles in commissioning, and within statutory and non-statutory provider organisations. We have already mentioned the role of the Mental Health and Learning Disability Leadership Group which comprised Directors across the HSCB and HSC Trusts with input from other key agencies such as PHA and RQIA. It should be noted that some of these Directors had strong clinical and professional backgrounds, and had been well established within an executive role, whilst others were relatively new to role and may have come from other service domains. There was certainly a positive set of working relationships within the group, and whilst there was a well-articulated commitment to work collectively and collaboratively this was not always then evident in the subsequent partnership working. Below this group sat the RLDOG which was chaired by the HSCB, but comprised primarily Assistant Directors/Co-Director from the 5 Trusts. At times it was unclear what role the HSCB held within the RLDOG – whether their role was as convenor and facilitator, or to lead the co-ordination process and take a performance management role within the group. This contributed to a lack of clarity about leadership within RLDOG, and this meant that the commitment and engagement of senior staff from the HSC Trusts could be variable. More clarity about leadership within the RLDOG, with a clearer focus on achieving progress and delivering improved outcomes would have been more helpful. Whilst RLDOG was expected to work on a broader range of service developments and priorities across the learning disability domain, during the 6 months that the review team were involved it primarily focused on resettlement and access to assessment and treatment services within specialist LD hospitals.

5.3.3. The learning disability resettlement programme in Northern Ireland did not have an over-arching programme or project plan. Whilst it was in the commissioning plan as a strategic priority for 2019/20, and Trusts were expected to respond

accordingly, this meant that individual Trusts developed their own approaches to addressing the needs of their cohort of patients within the remaining MAH population. Some Trusts addressed this positively and developed fairly robust plans over time, but overall there was a sense that the programme was fragmented. There was certainly some evidence that HSC Trusts were planning in relative isolation. There were examples of Trusts entering discussions with providers about developing services in other Trust areas, without the 'host' Trust being informed or consulted. The HSCB convened another group called Community Integration Programme (CIP) which had a sole focus on the resettlement but it was unclear how this group's role differed from that of RLDOG, particularly given the significant overlap of membership. The HSCB had developed what they called the MAH template which HSC Trusts were asked to complete in relation to their MAH populations and plans for individuals. The review team supported the social care officer responsible for CIP to make some improvements to this so that it could be used more effectively as a 'tracker tool' and then this could support a performance management approach.

5.3.4 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia. The system seemed more pre-occupied with process and there was insufficient focus on solution finding and achieving positive outcomes quickly. The system was also prone to adopting 'crisis-management' approaches linked to pressures escalated from BHSCT in relation to difficulties within staffing or access to admission at MAH. This meant that the system was primarily reactive rather than proactive. We give further examples of how poor leadership hampered progress in delivery in later sections.

5.3.5 Overall the review team felt that the learning disability resettlement programme would have benefitted from an effective project managed approach, which we have seen used to good effect in other similar situations. This would have more effectively co-ordinated the efforts of the system as a whole, and ensured less variation in the overall delivery of agreed outcomes. It also would have facilitated more effective opportunities to engage with providers within the social care market in order to streamline the service developments required to support the resettlement process in a timelier way, and would have brought provider-informed solutions forward for consideration.

5.4 Leadership Engagement with People who Use Services and their Carers.

5.4.1 The review team met with the Chief Executive and Patient Client Council (PCC) senior leadership team who are undertaking the role of Advocate to the Public Inquiry and supported families during feedback on the findings of the Leadership and Governance review team. PPC advised that in their engagement, families talked about the invisibility of learning disability and expressed anger and a lack of trust in the HSC system. PCC also found in their

engagement with families that safeguarding was foremost in their concerns. PCC advised the review team that the pain and trauma for families was palpable and that a trauma informed approach would be needed to engage and support families who had been let down so badly.

5.4.2 The feedback from PCC concurs with the feedback the review team received in our own engagement with families in the BHSCT, NHSCT and SEHSCT and sets the context for consideration of leadership engagement with people who use services and their carers across the HSC system. The review team will address the issue of carer engagement in more detail in a chapter 10.

5.4.3 Families reported that they felt learning disability was invisible at government and policy level and comparison was made by some families to the profile of mental health services resultant from the Mental Health strategy and appointment of a Mental Health Champion. Many families reported their fatigue, the emotional toll of life long caring and battling for resources and services over many years.

5.4.4 The Welsh Government 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system, what they referred to as the softer skills required to drive transformation and improve lives. The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services.

5.4.5 It is clear that across the HSC system there is recognition of the need for engagement and involvement of people with lived experience in both the planning and delivery of services however this is easier said than done. Two MAH carer representatives are members of MDAG and the review team observed both carers influencing and holding senior leadership to account through constructive challenge. However, the review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous other learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. The review team acknowledge that HSCB and the 5 Trusts had significant engagement with individuals with a learning disability and family carers in the development of the draft service model' We Matter'. However this level of contribution was issue specific and has not been sustained.

5.4.6 The review team noted some tensions in the relationships between Trust Directors due to the pressures associated with the challenge of accessing an acute learning disability bed when required. The establishment of a regional bed manager as agreed at MDAG would have significantly mitigated the tension however, there was significant delay by HSCB/SPPG in the actions required to establish this post. The review team were pleased to see and wish to

acknowledge that the three Directors co-dependent on MAH have recently committed to working collaboratively with a focus on the mutual aid required to respond to challenges at MAH but also to expedite the remaining resettlement challenge. The Directors have held solution focused workshops establishing time and space for reflection and the development of the trusted relationships that will be required to further enhance a one team approach.

5.4.7 Engagement events with family carers highlighted the importance of continuity of key workers in building effective working relationships at case work level but families also referred to a trusted key worker as their go to person when they had to navigate through different parts of the HSC system or when they were facing challenge or difficult decisions. The turnover of staff at both key worker and managerial level was reported by carers to directly impact on their trust in the HSC system. Relationship based HSC practice and continuity of key worker would significantly improve the experience of people at the centre of resettlement and their family members.

5.4.8 The impact of the turnover at HSC senior management level was raised by external agencies, both external statutory and independent sector provider organisations that generally have experienced stability in senior leadership teams. NIHE Supporting People leaders advised that there has been a loss of memory for HSC Trusts due to the turnover in senior leadership. Voluntary sector leaders also advised the review team that the turnover in Trust HSC leadership is challenging and highlighted variation across Trusts regarding being respected as valued partners with significant expertise. The voluntary and independent sectors are key stakeholders in the delivery of community-based services and will be central to the accountable care approach needed to meet growing demand and challenge. The review team acknowledged that each Trust has held engagement events with provider organisations but the review team saw it as a missed opportunity not to have collaborated given that many care providers deliver across all 5 Trusts.

5.4.9 At operational level, all Trusts have made significant efforts to establish effective engagement strategies as detailed in chapter 10 however, these are at an early stage of development. BHSCT has established a robust infrastructure mapping engagement from Trust Board level with a Non-Executive Director undertaking the role of learning disability lead at Board level, through dedicated forums in MAH and community learning disability services. It is significant that only a very small number of MAH families are in attendance at the MAH Forum meeting. This would suggest a level of disengagement of MAH families. Some MAH families told the review team that they are not willing to attend meetings as they have been led up the hill too many times and only now wish to engage if there is a concrete and viable plan for their loved one's discharge.

5.4.10 Effective engagement requires trust and openness and this has been seriously impacted due to the allegations of abuse at MAH which has made engagement more challenging. Some families have such a level of distrust that they are not willing to engage with the Trust. It is important that Trusts give this matter consideration. The review team saw missed opportunities for Directors to reach out to families who had raised specific concerns relying instead on delegating to other managers.

5.4.11 The review team had the opportunity to spend time with individual families actively listening to their experiences with some families advising that this made them feel respected and their experience valued. Families also advised that at case planning level they are not always respected as experts by experience.

5.5 Conclusions and Recommendations.

The voice of people with a learning disability and their family carers was not sufficiently evident within leadership processes addressing resettlement. The review team did not see evidence of effective co-production in strategic or operational service planning and delivery.

- Consideration should be given to the development of a Provider Collaborative to bring together the range of organisations delivering specialist learning disability care with statutory HSC leaders.
- HSC system should establish an effective programme and project managed approach for the learning disability resettlement programme
- People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system HSC Trust

6. Strategic Commissioning, Planning and Inter-Agency Working

In this chapter we will consider the models and approaches to commissioning and how this can support effective inter-agency working.

6.1 Prevalence of Learning Disability.

6.1.1 At the foundation of good commissioning is understanding the target population and their needs both collectively and individually. Whilst the review was primarily focussed on the population of people experiencing delayed discharge within MAH, this group of individuals with very specific needs based on their experience of living with a disability and in addition their experience of living in institutional care for an extended period of time, it is important to consider them in the context of the wider population of people with learning disability or intellectual disability in Northern Ireland.

6.1.2 The 2021 Northern Ireland (NI) Census data will include data on health and disability, but this element of the data will not be published before September 2022. However the University of Ulster and others undertook data analysis funded by the ESRC (Economic and Social Research Council), which was supported by health and social care organisations, both statutory and non-statutory in Northern Ireland. The research focussed on access and analysis of existing administrative data relating to learning disability in Northern Ireland between 2007 and 2011. Their key findings included prevalence data and demonstrated that within the overall Census Population the prevalence of learning disability was 2.2%; the prevalence rate amongst those aged 15 or younger was 3.8%, whilst the prevalence rate amongst those over 16 was 1.7%. Overall prevalence of learning disability ranged from 1.9% in the NHSCT to 2.5% in BHSCT. From the Census data they found that learning disability was also associated with greater deprivation. Within their conclusions the researchers comment that there is burgeoning international research which continues to detail the extreme disadvantages that are disproportionately faced by those in society living with a learning disability. Additionally they comment that learning disability specifically, at a population level, has either remained unrecorded and undetected or has been camouflaged/hidden/buried within general health data, that have referred to limitations in day-to-day activities or inability to work as a result of health problems or disability. Learning Disability Data & Northern Ireland, Ulster University, *'Enhancing the visibility of learning disability in NI via administrative data research'* Ctrl Click

6.1.3 Mencap is a charity which works across the UK with and for people with learning disabilities and their families. They have published figures calculated using learning disability prevalence rates from Public Health England (2016) and from the Office for National Statistics [2020). They estimate there are approximately 1.5 million people with a learning disability in the UK, indicating that approximately 2.16% of the UK adult population have a learning disability. They indicate that there are 31,000 adults with a learning disability in Northern Ireland, and 11,000 children with a learning disability (0-17).

6.1.4 In simple terms what we know about the 31,000 adults is that the vast majority live in their local communities either independently or semi-independently with support from their families, friends, and support services. Less than 10% of them live in registered care or supported accommodation schemes, and in most circumstances, these are still either within or close to their local communities. At the time of writing there were only around 60 people with learning disabilities in specialist hospital in Northern Ireland which equates to approximately 0.2 % of the total LD population, and of this small group about three quarters were awaiting resettlement or discharge to new permanent homes. In considering the needs of this last group of people we have needed to look at how the system works to meet the needs of the larger population, and to look at how those commissioning services and those providing services ensure positive outcomes for this important group of individuals in our society.

6.1.5 We have commented in a previous section about the importance of developing a regional strategy and service model for services for people with learning disabilities in Northern Ireland. This strategy will need to describe this community and their diverse and varied needs so that regionally work can be completed to develop a strategic commissioning plan which can support the service delivery for this group of people. You will see later in this section that work was commenced by the HSCB and PHA on the development of a Learning Disability Service Model in 2019/20, which resulted in the co-production of a report called “ We Matter “ which is currently being considered by the DoH and will contribute to the production of the final strategy.

6.2 Commissioning Models

6.2.1 Whilst there are numerous models of commissioning the one that we have chosen to identify primarily is “Integrated Commissioning for Better Outcomes” which (ctrl click) was developed by NHSE, the LGA and ADASS as a practical tool for local authorities and NHS commissioners to support improving outcomes through integrated commissioning. It was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. It

emphasises that effective commissioning relies on a strong focus on people, place and population.

The framework identifies what matters most to people:

- *Being the person at the centre, rather than the person being fitted into services.*
- *Citizens, people who use services, patients and carers are treated as individuals.*
- *Empowering choice and control for those people.*
- *Setting goals for care and support with people.*
- *Having up-to-date, accessible information about services.*
- *Emphasising the importance of the relationship between citizens, people who use services, carers, patients, providers and staff.*
- *Listening to those people and acting upon what they say.*
- *A positive approach, highlighting what people can do and might be able to do with appropriate support, not what they cannot do.*

6.2.2 The framework draws on a definition of commissioning developed by the Cabinet Office and Commissioning Academy in its statement about public sector commissioning.

"*We commission in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience."*

6.2.3 The second example is designed to help the voluntary sector work with the statutory sector and is based on the well-known commissioning cycle model. It describes the 4 stages of commissioning within the commissioning cycle as:

Analysis: this stage aims to define the change that is needed by defining the need – the problem that needs solving – and the desired outcome.

Planning: involves designing a range of options that will work to address the issues identified against the desired outcome.

Securing services: is the process of funding the option or range of options agreed to deliver the defined outcome via an agreed funding method – grant funding, contracting, etc.

Reviewing: entails evaluating the chosen option(s) to see what has worked well and what can be improved further.

Model of Commissioning

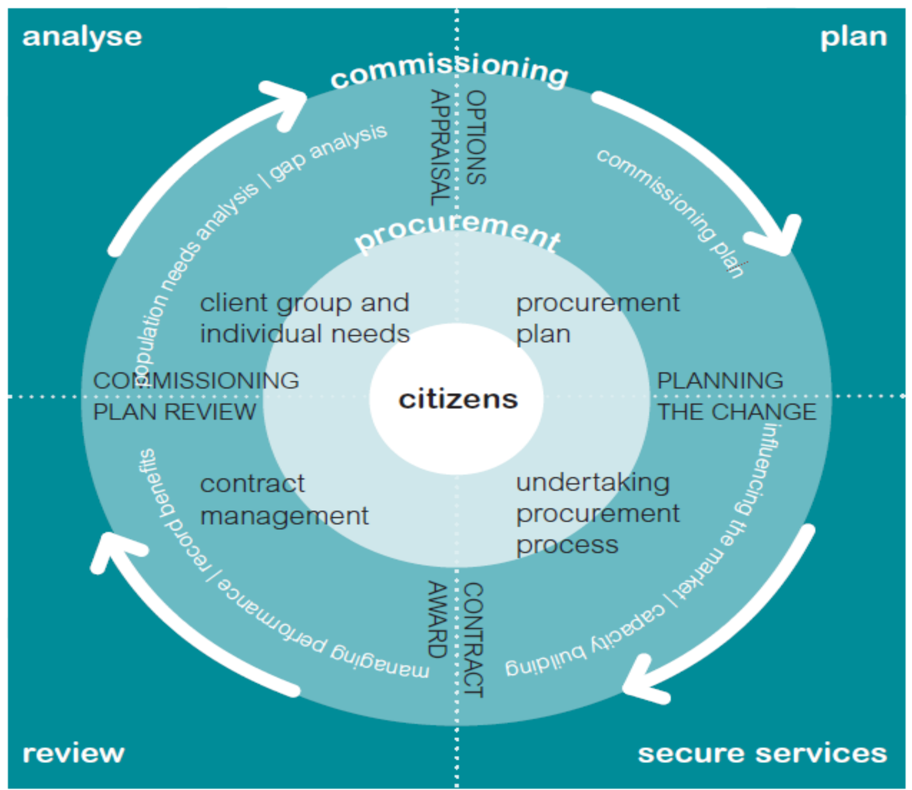


Fig 1

6.2.4 It is important to understand that commissioning activity will be essential at all levels within the health and care system. Strategic commissioning needs to support a population based approach underpinned by a strong assessment of needs, which is delivered by senior strategic leaders in partnership with other parts of the system. Locality based commissioning requires HSCT's to ensure that at a local level these strategic ambitions are delivered through the effective purchase and supply of a broad range of directly delivered and commissioned services from providers across the independent providers, both private and charitable/" not for profit". This locality-based commissioning should ensure a sufficient supply of key services including access to registered care in nursing and residential homes, and access to accommodation providing care and support for people with significant needs. Both of the above need to relate closely to 'micro-commissioning' which is where care and support is commissioned in a bespoke way for the needs of an individual through a detailed understanding of their specific needs and requirements, resulting in a personalised care solution. Micro commissioning is directly aligned to the individualised care planning which is described in a later session, and must be underpinned by a commitment to co-production with the individual and as appropriate with the involvement of family.

6.2.5 The review team needed to look at how this broad approach to commissioning had been applied to the needs of the cohort population of people who remained in MAH and who required to be discharged to appropriate community-based accommodation with access to ongoing care and support appropriate to their needs. The approach we took was to review the programme that had been developed in England to address the needs of a similar population; to consider the framework for commissioning both health & care and housing services; and to review how these arrangements had been applied in practice to support the resettlement of the group of people who had been prioritised through direction from the Permanent Secretary.

6.3 Transforming Care in England.

6.3.1 "Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 by NHS England, Local Government Association, and Association of Directors of Adult Social Services (ADASS). The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. The report relied heavily on a report commissioned by NHS England from Sir Stephen Bubb which reviewed how to accelerate the transformation of key services that people with learning disabilities and their families were looking for. The catalyst for this reform came after the shocking expose by Panorama/BBC in 2011 of institutional abuse of people with learning disabilities and/or autism at Winterbourne View, an independent private hospital at Hambrook in South Gloucestershire. The key organisations committed to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all organisations.

6.3.2 Central to the approach within Transforming Care was **a commitment to empower people with learning disability and their families**, and to strengthen people's rights within the health and care system. A key recommendation from Sir Bubb was for NHS England to introduce a "right to challenge "by providing a Care and Treatment Review (CTR) to any inpatient or inpatient's family which requested one. CTR's were to be embedded as "business as usual". Early evidence showed that the use of CTR's was effective in speeding up and strengthening discharge planning for those individuals in specialist learning disability hospitals.

6.3.3 A guiding principle in the approach was to ensure that people get the right care in the right place, and to ensure that people with learning disabilities and/or autism were discharged into a community setting as soon as possible. In

parallel there would be the development of robust admission gateway processes so that where an admission to hospital was considered from someone with a learning disability and/or autism, that a challenge process would be in place to check that there is no suitable alternative. The ambition was to reduce the number of people in inpatient settings, reduce their length of stay, and ensure that there was better quality of care both in hospital and community settings. Critically the process also required that where an individual is identified as requiring admission to a specialist learning disability inpatient facility that they have an agreed discharge plan from the point of admission. Work was undertaken in parallel to ensure that services for people with learning disability and/or autism who also have a mental illness or behaviour that challenges were improved both within inpatient and community support provision.

6.3.4 The above approach was supported through strategic commissioning by NHS and local authorities who had a shared responsibility to fund care and support throughout the pathway. This required the health and care system to develop quality standards and outcome metrics which were reflected within the NHS Standard Contract and were then applied with assurance processes undertaken by clinical commissioning groups at a local level to ensure that there were robust arrangements to monitor that individuals were receiving the right care in the right place. To support this strengthened commissioning there was a refocus on the quality of data and information so that those implementing commissioning intentions had access to the right information to ensure effective analysis and decision support.

6.3.5 Within Transforming Care there was a renewed commitment to strengthen regulation and inspection. The Care Quality Commission (CQC) were required to further refine its inspection methodology for mental health and learning disability hospital services, and to ensure that regulatory action is taken. Central to this was an explicit commitment that CQC would work with other partners to develop a clear approach for ensuring that unacceptable mental health and learning disability services were closed through use of its enforcement powers.

6.3.6 In 2017 NHS England followed up with model service specifications within the Transforming Care Programme in the context of "Building the Right Support – National Service Model " as a resource for commissioners, The model service specifications particularly focussed on (1) enhanced and intensive support, (2) community based forensic support, and (3) acute learning disability inpatient services. These 3 aspects of the service model describe the specialist health and social care provision aimed specifically at supporting people with a learning disability who display behaviour that challenges.

6.3.7 The review team subsequently met with senior officers from the Kent and Medway Integrated Care System who had been responsible for implementation of Transforming Care within their system as strategic commissioners. Their overall conclusion was that Transforming Care had been effective in ensuring a more targeted approach particularly in relation to admission avoidance through more effective gate keeping, and the provision of the dynamic support framework, which was delivered through an inter-agency forum to ensure effective strategies were in place for individuals identified at risk of admission. Additionally, they had received funding from NHSE to improve access to 24/7 intensive support teams. Transforming Care had also ensured that there were fortnightly reviews of all inpatients with a clear focus on the trajectory and progress over time for the individual.

6.3.8 In Kent and Medway there had been a renewed effort in terms of governance with the development of a new governance framework and an oversight board to ensure that partners were accountable for commitments and performance. However even with this strengthened focus 66% of the original population identified still were awaiting resettlement. They reported that there had been some issues in relation to effective working with the Ministry of Justice in relation to those individuals who were within justice domain, and in some situations local authorities had been slow to undertake and progress housing needs assessments. Positives had been the development of a Positive Behaviour Support framework of accredited providers, and a central source of capital funding to support bids for discharge plans for individuals who had specialist accommodation needs. More recently in the early part of 2022 they had found an increase in crisis referrals which they felt could be an acuity surge related to the aftermath of Covid.

6.3.9 At a national level organisations such as Mencap and the Challenging Behaviour Foundation monitor the monthly published data from NHSE and provide a commentary on progress. This reflects a view that whilst Transforming Care has provided an effective framework for the delivery of enhanced services to people with learning disabilities and/or autism whose behaviour can challenge the improvement has been slower than originally hoped for within specified targets, and there is a concern nationally about the growing number of young people being treated within inpatient settings.

6.4 Commissioning of Health and Social Care services in Northern Ireland.

6.4.1 Up until April of 2022 the responsibility for the commissioning of health and social care services sat with the Regional Health and Social Care Board (HSCB) and the Public Health Agency (PHA) in partnership. These bodies set their key priorities and areas for action within a commissioning plan, in response to a Commissioning Plan Direction issued by the Department of Health.

6.4.2 For our purposes we wanted to look particularly at the commissioning plan for 2019/2020, as this identified some actions which were required in light of the exposure of significant abuse of individuals living in MAH which was managed by the BHSCT. The commissioning plan also identifies how resources will be allocated to Health and Social Care Trusts and other providers to maintain existing services and develop new provision.

6.4.3 There are a few general points of note in relation to the 2019/20 commissioning plan. There was little reference in the earlier sections of the document to the needs of people with learning disability in terms of emerging issues or key policy and strategy. It did refer to the production of the "Power to People "Report in 2017 looking at the possible solutions to the challenges facing the Adult Social Care and Support System in Northern Ireland. Additionally, it highlighted the continued commitment of strategic commissioners to supporting Personal and Public Involvement to improve patient and client experience. Central to this would be the embedding of co-production within collaborative working of health and social care systems, including the adoption of co-production and co-design models for the development of new and re-configured services.

6.4.4 In terms of the financial resources made available to Trusts and other providers to meet the needs of people with learning disabilities and their families this amounted to 6.58% of the total allocation for health and social care in Northern Ireland, which comes to approximately £342 million. It should be noted that these allocations may not meet the full cost of services and there may be additional cost pressures emerging for certain groups.

6.4.5 In terms of the specific commissioning commitments in relation to learning disability services made within the 2019/2020 HSCB & PHA Commissioning Plan, these are laid out in a separate short chapter of the overall report. There is a commitment to continue to adopt the Bamford Report principles when developing services for people with learning disabilities, with a particular emphasis on supporting integration, empowerment and 'ordinary lives'. There was also commitment to co-produce with a broad range of stakeholders including people with learning disability and their families, a Learning Disability Service Model (LDSM) based on a regional review of services. Within the population sections of the plan there was no specific reference to the numbers

of people with learning disabilities, although the plan did note that, “the number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland.”

6.4.6 There were 2 strategic priorities identified which are of relevance to the resettlement programme for people with learning disabilities. The first states “Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of MAH (and other incidents affecting NI patients in private LD hospitals). In relation to this priority the Provider Requirement was, “Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge. (CPD2.8)”

6.4.7 The second of the strategic priorities was, “Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7). In relation to this priority the Provider Requirement stated, “Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.”

6.4.8 In addition there was a specific Skills Mix/Workforce area identified within the commissioning plan for action. This highlighted that, “Effective arrangements should be in place to develop multi-disciplinary services in community settings to address the actions required within the Independent Review of MAH.” The Provider Response required in relation to this area was that “Trusts should demonstrate plans to recruit multi-disciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.”

6.4.9 These elements of the HSCB’s commissioning plan clearly laid out the expectations of both the Department through its directive and the HSCB/PHA response to progress actions directly relevant to the delivery of the resettlement programme in Northern Ireland. HSCT’s would have been expected to reflect these within their Trust Delivery Plans (TDP’s) so that commissioners had an understanding of the actions Trust’s proposed which could then be monitored at a regional level for progress.

6.4.10 In subsequent sections we will look at how these clear commissioning intentions were executed and to what extent these requirements were delivered.

6.5 Commissioning of Specialist Housing with Support for People with Learning Disabilities in Northern Ireland.

6.5.1 In order to consider how the Trusts were to meet the objectives laid out above it is important to understand the role of the Northern Ireland Housing Executive (NIHE) and housing associations/charities in terms of the provision of specialist housing with support for adults with learning disabilities. The NIHE is the largest social housing landlord in Northern Ireland; it is required to regularly examine housing conditions and housing requirements; it is also required to draw up a wide ranging programme to meet these needs. For individuals with housing needs that have additional support needs this is addressed through the Supporting People Programme. The Supporting People Programme helps people to live independently in the community and is administered by the NIHE in Northern Ireland on behalf of the Department for Communities. The Supporting People Programme grant funds approximately 85 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland, with the total programme operating an annual budget of £72.8m in 2021/22. In relation to schemes for people with learning disability, the current provision has the potential to support 1334 individuals in 149 accommodation-based schemes. With an annual budget of £16.3 million.

6.5.2 The 2015 review of Supporting People recommended the introduction of a strategic, intelligence led approach to identify current and future patterns of need. Consequently, the NIHE and partners developed a Strategic Needs Assessment (SNA). This provides a comprehensive picture of housing needs for people who require additional care and support. It highlighted that people who are living with learning disability mostly require accommodation-based support rather than floating support as their disability is lifelong. A time-bound floating support intervention in these cases is not deemed an adequate intervention. Although floating support services offer the opportunity to allow individuals to remain in their own homes, respondents noted that this does not negate the need for accommodation services for those living with a greater complexity of need.

6.5.3 In terms of the SNA for people with learning disability they conclude that the analysis of current need suggests that there is an undersupply of 224 units. Research previously commissioned by the NIHE (2016) in reference to the resettlement of individuals living with learning disabilities from long stay

institutions highlighted that for these people there are several elements of supported housing services that are important:

- location or at least access to public transport network,
- safety
- Integration into the community.

6.5.4 These are important to the individuals to allow for their own independence and the feel of being part of a community. It is apparent from their research that the demand for learning disability services and in particular autism services has increased due to improved diagnosis and treatment services, which in turn will lead to an increased demand on housing support services. As the future calculations show, it is estimated that there will be an undersupply of 479 units for this cohort within a ten-year period.

6.5.5 Additionally, the SNA highlights the important issue of access to capital for housing development. Some providers have highlighted that capital investment would allow them to provide the required level of service to meet the growing demand as well as a wider range of housing support services.

6.5.6 It also refers to some early joint planning work between the NIHE, HSCB and HSCT's in relation to improving planning for the needs of people with learning disabilities. The information gathered and analysed in 706 person pilot conducted by HSCB with HSCTs for people with learning disability the report identifies could help inform future strategic needs assessment particularly if standardised approach were developed.

6.6 How commissioning operated in practice to deliver the resettlement programme for the people awaiting resettlement from MAH.

6.6.1 The commissioning plan from the HSCB/PHA had made an explicit requirement for the resettlement of the remaining people awaiting discharge to be progressed at pace.

6.6.2 In order to progress the HSCB convened a number of groups to support this process. There was a Mental Health/Learning Disability Strategic Leadership Group comprising senior leaders from the Directorate of Children and Social Care in the HSCB and the Directors responsible for learning disability services in each of the Trusts. This group had a leadership role across the whole of mental health and learning disability services, and held a collective strategic responsibility for the delivery of resettlement. This group sponsored 2 subgroups which comprised officers of the HSCB and senior operational staff

from the Trusts, including the Assistant Directors/Co-Directors responsible for learning disability services. Initially this only included representation from Belfast, Northern and South Eastern Trusts as the remaining people in MAH awaiting discharge were the responsibility of these organisations by virtue of the individual's original place of residence. These subgroups were (1) the Regional Learning Disability Operational Group (RLDOG) which included some representation from NIHE, and other agencies such as RQIA, and (2) Community Integration Programme (CIP) which looked more specifically at the issues pertaining directly to the resettlement programme.

6.6.3 The review team were able to observe and participate in all of the above groups and in addition had specific meetings with each of the Trust's senior leadership teams responsible for learning disability resettlement.

6.6.4 It was positive that the HSCB had created a structure of groups and meetings to progress the resettlement programme and address related issues, particularly in relation to access to learning disability hospital beds for assessment and treatment. There was a clear commitment from senior leaders to support the delivery of the resettlement programme and to work jointly to face and address the significant challenges.

6.6.5 However we felt that overall the commissioning of services was poorly framed and lacked effective performance management. This meant that the HSCB (and more recently SPPG) has struggled to achieve timely impact in ensuring the Trusts secured new homes for the people awaiting discharge from MAH.

6.6.6 There were a number of particular weaknesses which the review team identified. The HSCB were using a basic table to monitor the status of the individuals in the target population, which the review team assisted with re-design. Updates on this revised 'tracker tool' were sometimes only provided after chase up, and often not validated by the respective Trust AD/Co-Director, so may not have been reliable. Attendance at these key meetings was generally poor and inconsistent, contributed to in some instances by the too frequent changes in personnel in significant delivery or planning roles. Hopefully this report will be a catalyst for the SPPG to review with its partners the effectiveness of both CIP and RLDOG.

6.6.7 Whilst colleagues from other agencies – NIHE and RQIA – were involved in RLDOG it was sometimes unclear how they were expected to engage in the activity to progress schemes and proposals at speed. In particular the housing professionals held a wealth of information and data about activity in the existing system and had expertise in both design and delivery of housing schemes which wasn't always drawn on by colleagues from health and social care. Housing colleagues described how they felt the inter-agency working had

become less evident and effective in recent years, partly due to the lack of stable leadership and management arrangements at times in health and social care. They felt that some of the current senior staff lacked the understanding of the housing and Supporting People sector that their predecessors had demonstrated.

6.6.8 Whilst there was a verbalised commitment to working collaboratively, this was sometimes hampered by poor communication between the key partners. This was especially significant where a lead Trust was developing or planning a scheme which had the potential to provide accommodation for individuals from other Trusts. In some instances plans had not been shared with other partners which meant they weren't sighted on proposals for developments to be located in their Trust area, without their involvement in the planning, which had potential to place demand and pressure on local learning disability and other services.

Perhaps the most significant area of concern was the scrutiny of the proposed accommodation schemes and the supporting business cases to develop those schemes by the HSCB and individual Trust Boards. This rarely involved rigorous assurance that the planning for schemes would deliver new accommodation for individuals awaiting resettlement within a reasonable timescale. Subsequently the stated ambition that all people awaiting discharge from MAH would be resettled by the end of 2019 was completely missed, with slow progress verging on inertia beyond that point.

6.6.9 Having set out the regional landscape for strategic commissioning of health, social care and housing we will move in the next sections to look at how Trusts have progressed the individualised care planning (Chapter 7) and local commissioning of new provision to progress the resettlement plans developed for individuals.(within Chapter 8)

6.6.10 Across the system the review team were concerned that there were significant examples of poor or slow decision making, limited communication to support a fully collaborative approach, and weak management grip to address practical barriers that delayed positive outcomes being achieved – an example of this was transition/discharge plans being delayed for sometimes lengthy periods because required adaptations to property had not been completed, or legal advice in relation to placement matters had not been satisfactorily addressed.

6.6.11 There were a few legitimate challenges faced by the HSC system which we acknowledge compromised delivery within agreed timescales. The obvious challenge across the whole system was the global pandemic and the significant impact this had on capacity. This impacted further on workforce issues which all parts of the system described as placing them under real difficulties. Less likely to have been anticipated were the issues in relation to building and

estates , as new providers experienced unprecedented pressures in relation to the escalating cost and reduced supply of building materials which slowed the delivery of some schemes.

6.6.12 It is worth noting that all of the Trusts had engaged with some of the well-known providers in the not-for-profit sector, several of whom had a well-tested track record of meeting community demand for care and support to individuals with learning disability and behaviour that can challenge. This had resulted in a small number of resettlements being achieved through the design and delivery of high-quality singleton placements. Some of the families that we had engaged with told us stories of truly transformational and life changing experiences when their relative moved on from hospital to these schemes, and we will return to this in Chapter 8 when we look at the Operational Delivery of Care and Support.

6.6.13 However, it should also be noted that generally the review team found that Trusts often initiated planning for proposed new accommodation schemes without fully exploring the opportunities for potential provision within either existing or re-designed provision. If this had been possible then options for resettlement could have been developed in a much more speedy way.

6.7 Shaping the Independent Health and Social Care Market for People with Learning Disability

6.7.1 In the last few decades across the UK and more widely we have seen a significant shift away from hospital based long term care for people with learning disability towards community based provision. This shift has been driven by a clearer commitment to respecting the human rights of people with learning disabilities which has been enshrined in health and social policy.

6.7.2 Large scale institutional care has been replaced by a mixed economy of alternative care arrangements ranging from large scale group living to individualised specialist housing with dedicated care and support.

6.7.3 In England the responsibilities for market shaping are enshrined in the Care Act (2014) which states that each local authority “Must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person wishing to access services in the market:

- Has a variety of providers to choose from who (taken together) provide a range of services
- Has a variety of high quality services to choose from

- Has sufficient information to make an informed decision about how to meet the needs in question."

6.7.4 The Care Act reinforces that commissioning should be at the heart of personalised care and support. This includes commissioning with health and care organisations but goes further to include engagement with community development and working with other agencies, for example the community sector.

6.7.5 Whilst a similar statutory responsibility is not placed on HSC Trusts, they do have legal responsibilities to provide services, and should do this not only through direct provision but also by purchasing services from independent sector providers. Implicit within these broader responsibilities is a need to support and shape the market to ensure robust supply and to secure value for the public purse.

6.7.6 The review team found that health, social care and housing agencies held significant data on the current market provision relating to services for people with learning disability. RQIA hold information on each registered provider of nursing or residential care and can provide information not just on the capacity of those providers but also can provide quality information through a highly regulated inspection process. In addition, they are responsible for registering the domiciliary care element of supported living schemes which are responsible for providing the support element. We were impressed by the data that the NIHE hold relating to the 149 accommodation based supported living schemes which included both activity and financial data relating to both housing and HSC investment in these schemes, where the balance of the funding for each scheme is based on a functional analysis of the housing support vs care needs of the clients within the scheme.

6.7.7 However, the review team found that this data was not routinely shared by partners across the sector and that there was no strategic overview of what the market was providing for adults with learning disability across Northern Ireland, and at what cost. Given the availability of significant data we would expect that both strategic and local commissioners of care and housing would undertake some analysis to develop a 'supply map' of care and specialist housing for people with learning disability in Northern Ireland. This could inform strategic commissioning and market shaping, but it would also be of benefit to care managers, individuals seeking care and their families so that they understood the options available to them which could promote choice. This should be a live and dynamic picture of supply.

6.7.8 The review team gathered information from a range of sources, and undertook some analysis to establish an initial supply map, and identify commissioning trends. We will address within the recommendations. Below is a table which shows the overall range and location of registered care settings and supported living schemes in Northern Ireland. This sector provides accommodation capable of meeting a diverse range of needs, all located within the community. In total there are somewhere in the region of 2,500 places in the community for people with learning disabilities and a significant minority of the schemes have been devised to accommodate individuals who additionally have mental health difficulties or behaviour that can challenge. The cost of care across the sector is highly variable and is linked directly to the level of support and care required. For those individuals who live in the registered care sector all of the care costs are met by health and social care (although there could be a small number of 'self-funders'). HSC Trusts purchase places in registered care setting either through block contract or on a 'spot purchased' basis for individuals.

	Learning Disability	Residential Care Places		Supported Living	
	Disabilty /Nursing Home places	Statutory	Independent	Statutory	Independent
BHSCT	4 N-Homes/103 Places	6 RCH/39 Places	4 RCH/40 Places	7 Schemes	18 Schemes
NHSCT	8 N-Homes/247 Places	2 RCH/15 Places	6 RCH/58 Places	6 Schemes	27 Schemes
SHSCT	6 N-Homes/166 Places	0 RCH/0 Places	6 RCH/57 Places	13 Schemes	11 Schemes
SEHSCT	2 N-Homes/ 55 Places	2 RCH/15 Places	11RCH/180 Places	5 Schemes	38 Schemes
WHSCT	1 N- Homes/ 35 Places	5RCH/55 Places	6 RCH/ 88Places	2 Schemes	15 Schemes
Total	21 N- Homes /606 Places	15RCH/123 Places	33 RCH/423 Places	33 Schemes	109 Schemes
				Total of SP = 1420 Supporting People Tenancies/144Schemes	

(RCH – Registered Care Home) Fig 2

6.7.9 For those living within the housing with support provision the individual is usually funded through a combination of rental income which is commonly paid through housing benefit, an element for housing support paid from Supporting People funds, and then a care element paid for by the placing HSC Trust. Obviously in the case of supported living, the financial costs are spread more across 2 government departments – communities and health – and then arranged through the NIHE and HSC Trusts. In supported living the individual will have a secured tenancy, which ensures rights as a tenant under the relevant housing legislation. Additionally, the individual will be eligible to apply for

personal benefits and therefore could have more disposable income which can support greater financial choice.

6.7.10 The review team undertook a preliminary analysis of the market and in this context there were some interesting features of the market in Northern Ireland which merit some note. There are vacancies across all sectors, although the data on this wasn't readily held or available when we asked for it from Trusts, yet when talking to providers they all reported some level of vacancy across provision. For some providers in the private sector this was a particular issue in terms of sustainability, and they stated a willingness to work with local commissioners to adapt their services to be more appropriate to need and demand both now and in the future. Across the supported living sector there was somewhere in the region of 5% vacancy, which whilst relatively small did provide some opportunities to meet emerging demand, although the SNA completed by the NIHE indicates that they believe there is under provision for people with learning disability at present.

6.7.11 HSC Trusts continue to be a major direct provider of services to this client group both in registered care and supported living. Trusts operate 31% of the registered care settings for people with learning disabilities accounting for almost a quarter of the registered care places. In the supported living accommodation schemes 24% of the schemes were operated by the local HSC Trust. There is considerable variability in the extent to which Trusts continue to operate as providers. For instance, the SHSCT operate 55% of the supported living schemes in its area, but the WHSCT operates 11% of the supported living schemes in their area. This raises some interesting questions which the review team haven't fully explored in terms of the delineation of roles for Trusts both as commissioners and providers of care.

6.7.12 In relation to the registered nursing home sector these are all private sector operators. There are 21 specialist learning disability nursing homes in Northern Ireland, and the majority are operated by local providers some of whom have entered the market because of a family related interest in learning disability care or are led by professionals who previously worked within statutory services. However, 60% of the specialist nursing homes are located within 2 Trust areas of the NHSCT and SHSCT, with the majority in the NHSCT.

6.7.13 Further strategic inquiry is merited in relation to the type of need being met by statutory versus non-statutory as anecdotally this appeared to be based on historical context rather than based on strategic decisions. There could be a rationale for the HSC Trusts continuing to be such a significant provider, especially if this was to meet a category of need that the market for social care had struggled with, but again anecdotally this didn't appear to be the case.

Providers pointed out that as statutory providers were using Agenda for Change terms and conditions in employment arrangements within their direct provision, this placed Trusts at a tactical advantage in terms of recruitment and retention of staff. We will return to this issue in the later section on workforce.

6.7.14 Engagement with Private Sector Providers: we engaged with provider sector providers through a number of focus group sessions organised by 2 of the network organisations representing providers across the independent sector. These were ARC (NI) and Independent Health Care Providers (IHCP). The sector engaged very readily in the review and were keen to give their views and share their experiences of working within the wider system. Generally, providers, especially those in the private sector, felt that the resettlement teams and HSC Trusts had not engaged them in a strategic discussion about the sector's potential in meeting the needs of people awaiting discharge from long stay institutions. Several providers described that whilst they may not have been considered in the first instance, there were several occasions where they had been asked to consider and had admitted some individuals who had experienced unsuccessful placements elsewhere. In these cases several of the subsequent placements had gone on to be both successful in terms of client outcomes and stability over time.

6.7.15 Generally, providers expressed concern about the lack of effective partnership between commissioners and providers. In particular they felt that HSC Trusts were unwilling to engage in negotiations around 'risk-sharing' in terms of contractual measures that ensure a reasonable level of income to support the borrowing necessary to allow capital development and borrowing. This was more of an issue for smaller providers who were newer to the market. Providers also expressed a general view that whilst there was extensive engagement with HSC Trusts care management staff and contracting teams in relation to contract review, there was little discussion about forward planning or potential for service development. Additionally, several providers worked with a number of commissioning agencies or HSC Trusts and commented on the variability in processes and overall approach. Given the size of Northern Ireland there definitely should be consideration given to the development of a commissioning collaborative operating under a single commissioning framework. Nursing and independent residential care providers commented that they were being expected to operate under out of date nursing/residential care contracts with amendment through letter of variation, and these arrangements were not fit for purpose. This proved unsatisfactory, particularly in the context of the complexity of need of some of the clients.

6.7.16 The statutory sector within health and social care have organised their activity through the Social Care Procurement Board (SCPB) which was chaired by the

Director of Children and Social Care at the HSCB/SPPG with representation from each of the 5 Trusts and legal services. The SCPB has been going through a 'refresh' process to review its role and how it operates. Its revised draft terms of reference include:

The Social Care Procurement Board will:

a) Develop a Social Care Regional Procurement Plan that places all approved procurement projects within the overarching strategic commissioning landscape and includes the rationale for each procurement project being taken forward.
b) Ensure any request for a regional procurement project is only approved when the project can demonstrate a clear and unambiguous link with the Programme for Government and strategic commissioning plan for a related programme for care.
c) Establish a Social Care Procurement Project Delivery sub group for the operational management of the Social Care Regional Procurement Plan, with the Chair of the sub group to be a member of the Social Care Procurement Board.
d) Establish additional specialist sub groups in response to strategic commissioning needs.

6.7.17 Whilst it is encouraging to see this renewing of the SCPB it is imperative that they engage effectively in broader strategic engagement with providers so that commissioning strategies are informed and shaped with intelligence from the sector itself. There needs to be a recognition that the commissioned services with independent sector constitute a multi-million pound investment which has a massive impact on the lives of people with disability. Additionally, as elsewhere in the rest of the UK and Europe there is a growing recognition of the demographic shift in the population of adults with learning disability/ASD and behaviour that challenges leading to massive increases in demand which are related to the exponential growth in numbers of people diagnosed with LD and ASD, and the improved life expectancy of people with learning disability.

6.7.18 Several Trusts have provided us with information about provider engagement events or have established regular provider forums, to improve their partnership working. This would be best progressed through greater regional collaboration which could be supported by the SCPB's prioritisation of this important area of work.

6.7.19 Critical to this work will be developing an understanding of the pricing structure for care, and in particular the significant variation in costs across the sector. It will be important to understand both financial viability and financial sustainability of this relatively small cohort of specialist providers.

6.8 Finance and Value for Money

6.8.1 Commissioners, both strategic (regional) and local (within Trusts) have a broad duty to ensure value for money in relation to all expenditure within the public purse. This responsibility is scrutinized by the Northern Ireland Office who can pursue Value for Money Audits in relation to key areas of work.

6.8.2 The review team were not required in the context of the terms of reference for this review to undertake a detailed analysis of the costs associated with the resettlement programme, but there are a number of observations that we would make in the context of strategic commissioning.

6.8.3 The review team have had discussions with finance officers within the HSCB regarding the commissioning of learning disability services, including the services provided at MAH and the alternatives being proposed through the resettlement schemes.

6.8.4 The costs associated with the funding of MAH is linked to the funding of the resettlement costs. In the past a 'dowry' system applied where each individual being resettled from a long stay hospital received an allocated sum to support their resettlement, but there was a broad acceptance that the dowry was often insufficient to cover the costs of the placement. Whilst the dowry was person specific once it was no longer required to support that named individual, then it could be incorporated in to the base funding for future community placements at some point.

6.8.5 In more recent years this has been replaced with a requirement that the HSCB would receive costed proposals for the resettlement of an individual, directly linked to the cost of a placement or place within a newly developed scheme, and there is an approval process. This requires the HSC Trust to submit a client specific business case for each individual with complex needs, in which the Trust is required to lay out provisions for capital and on-going revenue costs, and should demonstrate value for money to the public purse. The business case must also demonstrate what elements, if any, are funded through sources of funding outside of health, usually housing/supporting people funds. This include access to personal benefits – housing and welfare payments, rental costs, or Supporting People funding towards housing support and some elements of management costs within schemes.

6.8.6 In broad terms the costs associated with the funding for MAH is linked to the funding of the resettlement costs. There would have been an assumption that a certain proportion of resettlement costs were linked to an expectation of ward closure and decommissioning of beds as the patient population reduced. In reality there should have been a decommissioning plan agreed between the BHSCT and HSCB linked to the resettlement programme, but this doesn't appear to have been put in place.

6.8.7 In recent years the number of patients leaving the hospital has been relatively low. However in addition the number of patients remaining in MAH is substantially lower that the commissioned beds. Costs within MAH have

escalated dramatically as there has been an increased reliance on funding of substantial agency staff to replace staff who have been placed on suspension during the course of the PSNI investigation.

6.8.8 This has meant that in the last several years the BHSCT has had to seek additional funds non-recurrently from the HSCB to cover these additional substantial cost pressures.

6.8.9 The other factor to consider is the cost of the alternative homes that are being commissioned for people moving on from MAH through resettlement. Through the 'tracker tool' the Trusts have reported on discharge planning for each individual and where there is a scheme either nearing completion or with a costed business case approved they provide indicative costs. Not all Trusts provide this information, but based on the return from the NHSCT the annual costs of the new provision range from £212k to £500k per annum for the majority of clients. It should be noted that there was one client who had costs significantly higher than has been quoted in the range but as this was deemed an exceptional individual with what could be considered the most complex needs that individual hasn't been included in the range.

6.8.10 As stated previously the SCPB will need to consider benchmarking the costs of these specialist community placements so that SPPG, HSC Trusts and others can establish what 'value for money' looks like in this domain. Additionally it has to be recognised that the community placements should provide significant quality of life benefits to those individuals who have previously lived in MAH.

6.8.11 Whilst the review team did not have access to detailed cost per bed data for MAH, based on our discussions with finance officers it would appear that the cost of hospital bed in MAH per annum currently is significantly higher than even the highest costed placement within the range of placements provided by NHSCT, and substantially higher than the estimated average cost of a community placement. In addition it has to be considered that for placements in specialist supported living schemes, a proportion of the costs will be shared with housing.

6.8.12 In the context of the position laid out above there needs to be consideration of the opportunity costs in this situation. A simple definition of 'opportunity cost' is "opportunity cost is the forgone benefit that would have been derived from an option not chosen or pursued". The review team consider that if the resettlement of the target group of patients had been achieved more quickly and within the timescale of the original directive from the Permanent Secretary in 2018, then there were opportunities for cost efficiencies in relation to the cost of community placement relative to the cost of continuing hospital placement for these individuals. This may be open to alternative interpretation and debate, but there is certainly merit in considering this as part of any more formal evaluation of the resettlement programme.

6.9 Recommendations

In summary the conclusions and recommendations from this chapter are:

- The DoH needs to produce an overarching strategy for the future of services to people with learning disability and their families, to include a Learning Disability Service Model.
- In the context of the overarching strategy the SPPG will develop a commissioning plan for the development of services going forward. This should include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and plan for regional resettlement.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland
- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract for specialist learning disability nursing/residential care.

7. Individualised Care Planning

In this section we will review the policies, and discharge planning guidance in place nationally to identify good practice; critically review the individualised care planning arrangements in place in each of the 5 HSC Trusts and assess their effectiveness.

7.1.0 As part of evidence gathering, the review team issued a questionnaire to all 5 HSC Trusts requesting confirmation of the assessment tools and care planning procedures and processes relied on to support discharge planning.

7.1.2 Engagement with family carers and provider organisations, provided rich information to the review team in regards to the effectiveness and experience of discharge planning and this feedback highlighted a gap between the perception of statutory HSC Trust teams leading the discharge planning and the experience of other stakeholders.

7.1.3 The review team analysed the information returned by HSC Trusts and completed a review of research and available guidelines and best practice relating to individualised care planning. The review of policy and guidelines highlighted the need to plan discharge from the moment of admission. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units August 2018, (ctrl click) provides a useful checklist of what needs to be in place for effective discharge planning;

- At the point of admission, the care plan should include a section on 'when I leave hospital' and the discharge plan discussed at each meeting
- Ensure family and the individual are involved with clear goals agreed
- Discharge plans need to contain a date, an identified provider and discharge address
- Evidence that the person is being supported to develop skills for independence and living in the community
- Evidence that information is shared appropriately with providers to prepare for discharge with the outcomes of assessment and treatment clearly stated.

7.1.4 There are a range of relevant Guidelines to inform effective assessment and care planning. NICE guidelines- 'Challenging Behaviour and Learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (ctrl click) highlights the importance of understanding the cause of behaviour and need for thorough assessments so that steps can be taken to help people change their behaviour The DoH Guidance 'Positive and Proactive Care: reducing the need for restrictive

interventions (2014) (ctrl click) is also based on a positive and proactive care approach The Care Quality Commission, Brief Guide: Positive behaviour support (PBS) for people with behaviours that challenge (2018) (ctrl click) provides the policy position and helpful good practice case examples.

7.1.5 Promoting Quality Care' Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services(May 2010) (ctrl click) states that a crisis plan should be included in the care plan and specify triggers and warning signs with explicit proactive and preventative strategies in the care plan. Effective assessment and care planning is central to supporting the transition of individuals from hospital to the community who have highly individual communication and support needs. Guidance and policy highlight that an essential lifestyle plan alongside the positive behaviour support plan should be central to discharge planning in addition to core assessment tools. The Centre for the advancement of PBS-(BILD) (ctrl click) advocate a whole organisational approach to embed PBS with all staff having a basic understanding of PBS and its value base. The learning from resettlement placements that have broken down and feedback from families and care providers highlights that positive support plans have not always been in place and that further work is required to ensure regional standardisation in regards to the quality of assessments and the tools used.

7.1.6 Questionnaires returned by HSC Trusts highlighted a lack of consistency regionally in the documentation used to develop care plans supporting a person's transition from Learning Disability hospital to the community. HSC Trusts use a range of assessment templates which are not always collated into one document. All HSC Trusts used the Northern Ireland Single Assessment Tool (NISAT) DoH Procedural Guidance- February 2019 (ctrl click). However, this comprehensive care management assessment tool is generic and not sufficiently person centred. Some Trusts, appropriately supplemented the NISAT with a range of assessment tools, including 'Essential Lifestyle plans 'Promoting Quality Care assessment, Functional assessment, Motivation assessment scale and Behaviour support plan. If a person is displaying challenging behaviours, a functional assessment can help uncover the reasons behind that behaviour. Knowing the function, allows changes to be made that reduce challenging behaviour. It is essential that discharge planning is person centred and that the information is accessible and available to all the stakeholders involved in supporting the person to move on from hospital. This highlights that assessment tools will only be effective if the organisational culture is based on positive behaviour support for people with behaviours that challenge and staff trained to understand and evaluate communication and to implement proactive and preventative strategies in response to triggers and warning signs to avoid escalation and crisis. Review of strategic policy across

England, Scotland and ROI confirmed that all prioritised the development of a positive behaviour framework.

7.1.7 The review team recommend that HSC Trusts collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans. The review team recommend that the learning disability strategy / learning disability service model to be progressed by DoH takes the evidence base for PBS and learning from other UK nations into consideration.

7.1.8 The discharge process requires sufficient flexibility to ensure agility and prevent the process being risk averse, however, an overarching pathway that maps out who does what at critical stages of the process is required. The review found that there is no overarching resettlement/ discharge policy that informs the roles and responsibilities of the range of organisations, teams and individuals involved. Indicative timelines for case transfers between teams and organisations is required so that individuals and their families know what to expect at each stage of the transitions pathway. The review team recommend that HSC Trusts collaborate with all stakeholders to develop a resettlement pathway and operational procedure.

7.1.9 Most Trusts were clear that it is the community HSC Trust that has the lead role for discharge planning rather than the hospital team however, this was not consistently applied regionally. The review team worked with all HSC Trusts throughout the period of the review with agreement reached that the community HSC Trust held responsibility and accountability to lead resettlement planning once the patient had been identified as ready for discharge. The community HSC Trust will be reliant on the MAH team who have the contemporaneous experience of caring for the patient to provide clinical information and input to the care plan however the community HSC Trust should hold a challenge function in addressing any discharge delay.

7.1.10 The MAH resettlement co-ordinator has a central role in facilitating meetings and coordinating the information the hospital team need to share with community Trusts and provider organisations. Provider organisations had to develop their own care plans from information shared by the MAH team and the assessment completed by the relevant HSC Trust, whilst getting to know the patient during in-reach. They reported significant weaknesses with this approach.

7.1.11 It was generally recognised that it is a complex task to develop care plans for community living based on behaviours and triggers evident in an institutional setting. This highlighted that the community teams should lead the discharge

care planning processes with active collaboration with families and provider organisations which was not always evident in the review.

7.1.12 Learning from failed placements and engagement events with provider organisations and with families, highlighted that not all care plans were robust in highlighting the key issues and risks for the individual. Families shared their experience of resettlement placements breaking down within weeks and months of the trial placement with recurring themes; staff not knowledgeable or trained in Positive Behaviour approach, inexperienced staff relying on physical interventions and care plans that did not reflect the level of support that would be required in the community.

7.1.13 Families were confused by the process of handover between teams due to a lack of clarity regarding the roles of the community learning disability team, the dedicated resettlement team and the MAH team when a patient is discharged on trial. Families were unclear of the process for standing down the resettlement team and transitioning to the community learning disability team. Some families who had experienced placement breakdown during trial resettlement felt that the process was too focused on the MAH multi-disciplinary team for advice and support rather than involvement and wraparound services from the community learning disability team. Some families expressed the view that their loved family member was returned to MAH at the first challenge when more should have been done to sustain the community placement. There should be a clear process mapped out through the resettlement pathway providing clarity of roles and mapping out indicative timeframes for transitions between teams for patients and families long the resettlement pathway.

7.1.14 Care providers reported a negative experience of care planning due to gaps in the information that should have been provided by HSC Trusts. Assessments were stated to be based on the current behaviours in an institutional setting and not on the hopes and dreams that should be central to strength based person centred planning

7.1.15 There was insufficient evidence of the learning from things going wrong being used to improve discharge planning regionally and no evidence provided that the learning is shared with care providers. Care providers also highlighted that the focus tends to be on what has gone wrong rather than on what is going right and that the HSC system should collate the learning from successful placements. The review team recommend that HSC Trusts collaborate with key partners to share the learning when things have gone wrong as well as the success factors when resettlement has worked well and celebrate positive resettlement stories.

7.1.16 The review team were tasked to review the care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. The terms of reference asked the review team to look specifically at the MAH population profile by the length of time the person has been in MAH, where they were admitted from and if resettlement has already been trialled. The analysis of the thirty six current in-patients and 4 patients on extended leave is presented in the following charts.

Table 1.1 MAH current population by length of stay (Inclusive of 36 in-patients and 4 patients on extended leave).

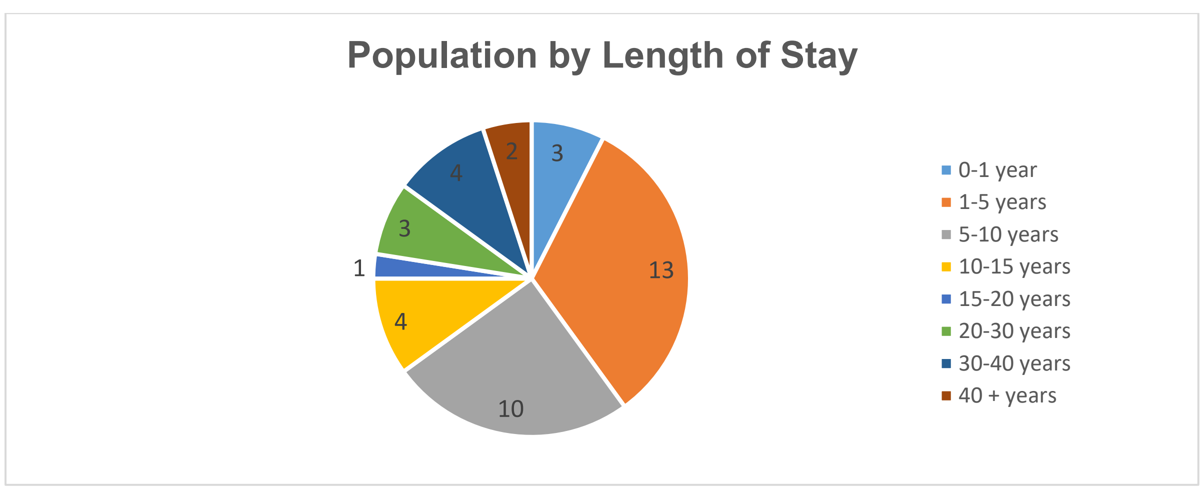


Fig 3

7.1.17 The original Patient Target List (PTL) was established to target long-stay patients for resettlement who had been in-patient at MAH for more than one year in 2007. The analysis of length of stay of the current in-patient population identified ten patients from the PTL list who have not been resettled of whom six have been in MAH over thirty years and 2 in MAH over forty years. The range of lengths of stay for the remaining 16 delayed discharge patients not on the PTL list, varies by HSC Trust. SEHSCT range between 2 and 4 years. BHSCT range between 2 and seven years and NHSCT range between 2 and ten years.

7.1.18 The hospital has been virtually closed to admissions over the past 2 years however, it is of note that the 3 admissions in the past year were all BHSCT patients. Two of these admissions were from a respite facility managed by BHSCT and one from a facility managed by an independent sector provider. It is clear that HSC Trusts are responding to a higher level of acuity and risk in the community than previously however, further action is needed to embed hospital avoidance measures through community treatment and intensive support to prevent further admissions and adding to the delayed discharge population.

7.1.19 The impact of new admissions on a long stay population is significant due to the challenge of managing very diverse and competing needs. The majority of patients in MAH are NOT on active treatment and should be progressing on a skills development and transitions pathway. Unplanned new admissions have the potential to impact on the opportunities and quality of life for longer stay patients if the focus in the hospital is on managing risk and crisis response. It is critical that community based crisis response and intensive support services are further developed to prevent crisis admissions.

Table1.2 MAH Admitted From

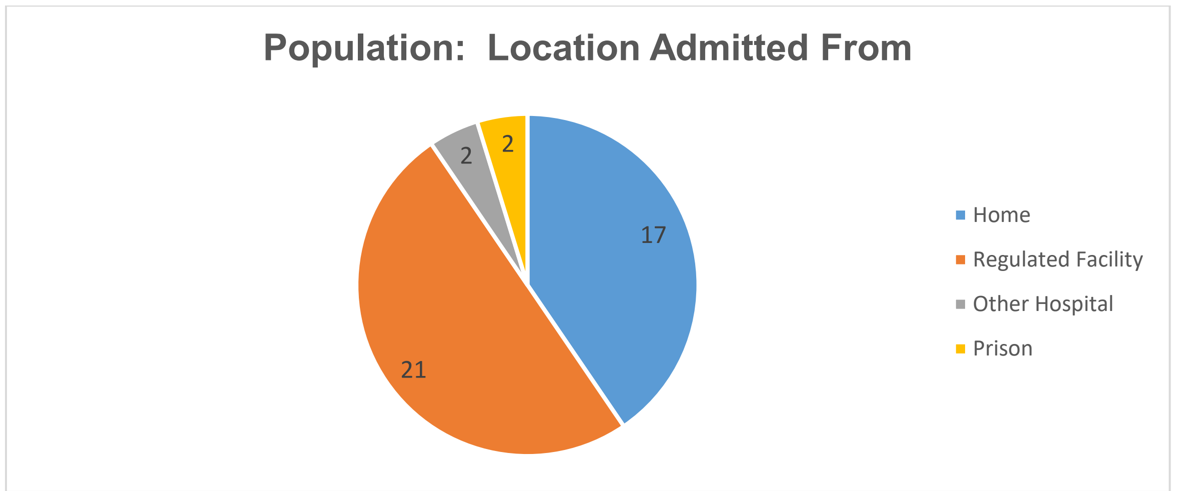


Fig 4

7.1.20 Patients with longer lengths of stay were more likely to have been admitted from home, but those admitted in more recent years were likely to have been admitted from a range of regulated facilities. Two patients transferred from prison and 2 of the MAH patients transitioned from the children's inpatient facility the Iveagh centre. Children & Young People with learning disability were not in scope for this review however, feedback from family carers stressed that a lifecycle approach to planning is essential to effectively project and plan for transitions and that children, young people and their family carers should have a say and input into planning adult services as a key stakeholder. Analysis of the data relating to where patients have been admitted from, highlights that recent admissions have all been from regulated learning disability facilities managed by both statutory and independent sector providers. The review team did not see evidence of the learning from these crisis admissions however, the evidence base and policy/commissioning direction in England and Scotland highlights the need to step up wraparound intensive support services to meet the needs of the individual but also to wraparound the staff teams often struggling to respond.

7.1.21 The review team had the opportunity to visit people in supported living environments who had previously been transferred to medium secure hospital in the UK and were now successfully returned to their home community. The success factors in sustaining the placement reported by both the Independent sector provider and the Trust was the level of collaboration, responsive and pro-active interventions by the Trust Learning disability forensic team. The independent sector care staff talked about the importance of building relationships and trust with statutory colleagues. The Welsh Government's 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system. The emphasis on these 'softer' skills within the Improving Lives programme of change is significant. The review team received feedback from statutory, independent sector providers and from families highlighting concerns about the lack of openness, trust and respect in relationships. Families reported that lack of continuity of key workers has impacted on developing trusted relationships alongside the fact that their trust in the HSC system has been broken due to the allegations of abuse at MAH. Care Providers and HSC Trusts expressed negative experiences in the contracting and monitoring of services due to a lack of trust.

7.1.22 It is critical that community based intensive wraparound services are developed to prevent placement breakdown and prevent hospital admission. However there is also a need to get back to basics and spending time repairing and building relationships which should be informed by the values underpinning the HSC Collective leadership strategy (ctrl click) to ensure effective person centred planning and collaboration with all relevant stakeholders

Table1.3 MAH current population Number of previous trial placements

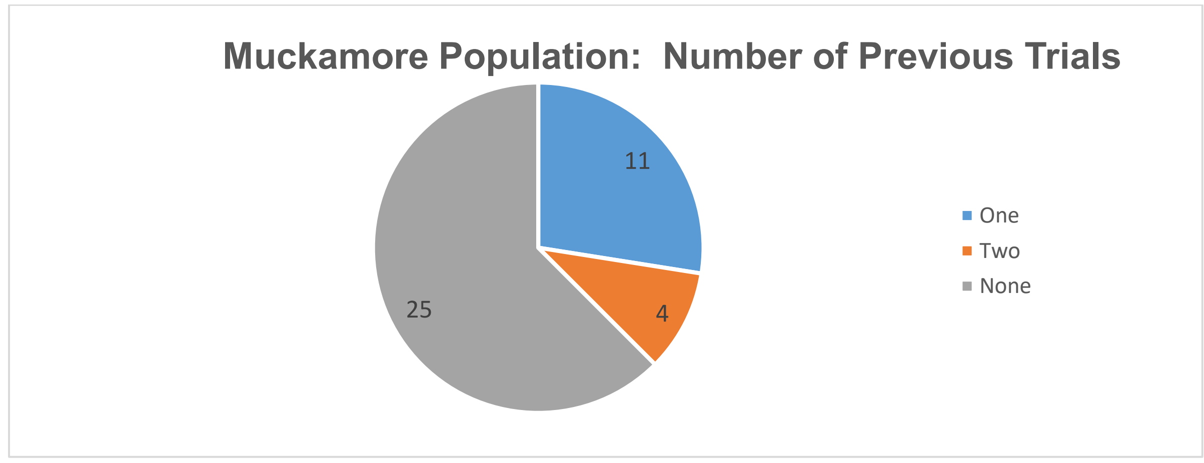


Fig 5

7.1.23 In regards to previous trial resettlement, the analysis confirmed that all PTL long-stay patients had at least one previous trial placement with one PTL patient

who had been offered 2 placements but would not leave the hospital. A small number of patients who had become institutionalised by having lived most of their adult lives in hospital were distressed by the experience of trial resettlement, which were then unsuccessful. This is a key reminder that whilst we should be ambitious for timely resettlement the primary importance is getting the resettlement right first time in order to prevent further breakdown causing trauma and distress. The majority of patients who have not yet had a previous trial placement are the more recent admissions or the small number of patients subject to a hospital order with restrictions with step down from detention requiring collaboration with the Department of Justice.

7.1.24 MAH serves 3 HSC Trusts, the BHSCT which manages the hospital, the NHSCT and SEHSCT. The WHSCT has its own Learning Disability in-patient beds at Lakeview Hospital and the SHSCT has its own Learning Disability in-patient beds at Dorsey hospital. There are a few out of area placements. SHSCT has one patient in MAH. NHSCT has one patient in Dorsey and one patient in Lakeview.

7.1.25 At commencement of the Review of Resettlement, there was a total of sixty Learning Disability in-patients delayed in discharge regionally; 46 at MAH, 8 in Dorsey Hospital and 8 in Lakeview Hospital.

7.1.26 The review team established the baseline MAH Population in June 2021 and updated the population baseline as of 11th July 2022. It is encouraging to note that there have been ten discharges between June 2021 and July 2022 however 3 admissions. The NHSCT had the highest in-patient numbers at commencement of the review however, BHSCT now has the highest number of in-patients.

Table 1.1: Patients by HSC Trust – June 2021

Trust of Residence	Number of In-Patients
NHSCT	21
BHSCT	16
SEHSCT	8
SHSCT	1
WHSCT	0
Total	**46**

Fig 6

Table 1.2: - Patients by HSC Trust-11th July 2022

Trust of Residence	Number of In-Patients
NHSCT	14
BHSCT	15
SEHSCT	6
SHSCT	1
WHSCT	0
Total	**36**

Fig 7

7.1.27 The review team critically evaluated the progress of resettlement plans as devised by the responsible Trust for each patient in MAH and reviewed all business cases which have been completed or are still in process, to identify any strategic or operational barriers and make recommendations for actions to accelerate the delivery of proposed pipeline schemes. The review team reviewed the data submitted by all 5 Trusts on the monthly tracker to HSCB/SPGG and met with Northern Ireland Housing Executive, Supporting People leads to validate information relating to Supporting People schemes. Through this analysis, the review team identified individuals where plans are absent or weak requiring alternative plans.

7.1.28 At the outset, the review team met with the Director and senior management team of each of the 5 HSC Trusts to discuss their approach to discharge planning, to clarify the specific plans in place for each patient and the business cases being progressed directly by the Trust or reliance on schemes being progressed by another HSC Trust. The review team assessed discharge plans against deliverability and timescale for discharge. There were common issues raised by all HSC Trusts with the key challenge to discharge noted as workforce recruitment and capability alongside gaps in the community services infrastructure required to maintain community placements.

7.1.29 Tracking resettlement from the 1980's, has seen a clear move over the years from large institutional settings to smaller nursing and residential homes in the community and progression to supported living models based on single tenancy or small number of people sharing

7.1.30 The focus currently has moved to new build bespoke schemes that have a minimal design to delivery timeline of between 2 and 5 years which has become a significant delay factor. BHSCT has 3 capital schemes in the pipeline. Minnowburn which was a BHSCT only scheme for 5 patients and the On-Site and Forensic schemes to accommodate patients from all 3 HSC Trusts. The timelines for the new build schemes have drifted and most are still at an early stage of development. The review team view the uncertainty of

projected discharge dates for these capital schemes as unacceptable and highlighted the requirement for alternative options to be pursued.

7.1.31 The review team were concerned that robust needs assessments had not been completed for patients identified for the On-Site and Forensic schemes resulting in a lack of clarity about the appropriate service model and whether registration of the On-Site scheme should be for a nursing home or residential facility. Robust Needs assessment should be the basis for any procurement or service development. It was a recurring issue throughout the review that insufficient attention has been given to needs assessment at individual case and population level.

7.1.32 The review team obtained information from Supporting People and data from RQIA in regards to regulated nursing and residential schemes which highlighted vacancies in current schemes. Feedback from provider organisations suggests that Trusts have not worked sufficiently with provider organisations to explore how current capacity could be customised to meet need with view to speed of implementation. This requires fresh thinking and imagination based on robust needs assessment. It would appear that the HSC system has become risk averse and focused on bespoke new build schemes.

7.1.33 HSC Trusts need to be clear about risk appetite based on robust Assessment of Need/Risk and analysis of what is working for similar needs in the community. Delivering this challenging agenda also requires a corporate and regional approach to ensure the relevant skill set promotes fresh thinking and delivery.

7.1.34 HSC Trusts narrative and reporting in relation to resettlement plans was repetitive, providing reassurance rather than assurance based on evidence. Trust Boards should have challenged the timelines presented for resettlement and queried contingency arrangements for expediting earlier discharges. At the commencement of the review, all HSC Trusts reported that discharge plans were in place for the majority of their patients however the review team's analysis identified that most plans were still at scoping stage and therefore lacked the robustness and detail required to establish a reliable trajectory for tracking performance. Delegated Statutory Function reports for all HSC Trusts focused on the lack of community living options, rather than on breach of Human Rights and did not provide the assurance required. There was insufficient challenge by Trust Boards and the HSCB/SPGG.

7.1.35 Four discharge placements had already been commissioned and had been available from commencement of the review including 3 planned discharges to Cherryhill (BHSCT Supported living). One of the Cherryhill discharges was delayed due to the wait for minor adaptation work. This matter should have

been escalated for urgent approval through senior management rather than rely on routine processes. Three of the Cherryhill discharges were delayed due to staffing shortfall and requirement to recruit additional staff. In light of the fact that discharge placements for 3 patients were available, there should have been a more strategic approach taken in regards to deployment of the workforce with view to reducing the MAH in-patient population. BHSCT had a strategic focus on the stability of the MAH workforce with daily monitoring and reporting given the reliance on agency staff. This appeared to impact on decision making about using agency staff to transition with the patient until sufficient staff could be recruited and trained. The bigger picture of reducing the population through more flexible utilisation of the workforce to expedite the discharges was raised by the Co-Director but not progressed. The complexity of the logistics associated with workforce allocation cannot be underestimated however, the delay and drift in discharging 3 patients added to the staffing pressures in MAH. Prioritising a consultation with legal services in relation to the fourth patient who had a placement already commissioned by community LD services was agreed but not actioned, resulting in drift. In this specific case, the community HSC Trust and the BHSCT should have been working more collaboratively to an agreed action plan. It was concerning to note the drift in these specific cases despite the opportunities being highlighted to the involved HSC Trusts by the review team. Whilst there are recognised delays associated with new build schemes there should have been more focus on those discharges that could have been expedited more speedily.

7.1.36 The review team completed an analysis of resettlement plans, revised the performance tracker tool and provided advice to HSC Trusts on the immediate actions required to accelerate resettlement and strengthen reporting and accountability arrangements.

- Advice to Trusts to rethink the deliverables to focus on speed of implementation given the unacceptable timelines for new build schemes still at initial development stage
- Advice to BHSCT to extend the TOR for the On-Site project chaired by Director to include the Forensic scheme given the inter-dependencies for the NHSCT and SEHSCT on both schemes
- Advice to NHSCT to engage the care provider for the new build scheme Braefields, to agree concurrent admissions rather than the eighteen month phased implementation as planned.
- Advice to Trusts to review available capacity in the nursing home and residential/ supported living schemes and agree how placements could be tailored to meet need
- Advice to Trusts to urgently re-assess patients identified for the Forensic scheme and bring forward individual discharge solutions.

- Advice to all Trusts to prioritise the focus on individual cases with an increased potential for early discharge rather than focus on new build schemes.

7.1.37 The landscape changed throughout the period of the review, with HSC Trusts revising their plans in recognition of the long lead in time for new build schemes. The review team welcome the fresh thinking and renewed collaboration between the Belfast, South Eastern and Northern Trusts evident from April 2022 resulting in solution focused workshops to address the long standing challenges associated with delayed discharge. Consideration was given to the development of an interim model on the MAH so that patients pending discharge to community placements would be cared for in a social care model as part of transition planning. However, due to the continuing pressure on workforce availability and capability which is evident in MAH, the thinking is rapidly changing with re-focus on building individual placement discharge options rather than on an interim on-site social care solution. The review team completed a stocktake of all plans at commencement and end of the review fieldwork and will present the analysis on progress on a Trust by Trust basis and summarise the projected discharges by end March 2023.

7.1.38 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

7.1.39 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made

significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

7.2 BHSCT – Regional Role as the Trust Responsible for MAH

7.2.1 Reducing the MAH population is a strategic priority and should be a significant measure in providing assurance about safe and effective care in MAH. Reducing the population would defacto reduce workforce challenges and support the remodelling of the hospital site with view to re-establishing patient flow and acute admissions. The Leadership and Governance report (2020) highlighted that the Trust focus on resettlement came at the cost of scrutiny of the Safety and Quality of care of those in-patient. Given that BHSCT has the lead role for the management of MAH as well as the delivery of 2 schemes that other HSC Trusts were co-dependent on, namely the Forensic and On-Site schemes, a review of BHSCT Board agenda and minutes for 1 year, 2020/21 was completed by the review team to identify the level of scrutiny and challenge to address the delayed discharges from MAH.

7.2.2 The analysis of Trust Board minutes confirmed that MAH is a substantive standing agenda item at each Trust Board with update report and papers on safety metrics and workforce presented by the MH/LD Director. Updates on the number of patients in MAH are provided however, there was limited scrutiny in regards to the resettlement plans for BHSCT patients or the capital business cases in development.

7.2.3 The review team found that the pendulum appears to have swung to a primary focus at Belfast HSC Trust Board on the development of safety metrics and workforce stability with limited challenge to the timelines proposed for resettlement of BHSCT in-patients.

7.2.4 The following updates on the MAH population and resettlement plans were provided to Belfast Trust Board by the Director of Mental Health and Learning Disability services.

- Oct 2020 Director reported 43 patients, 2 on trial and 1 on home leave. Further 5 BHSCT discharges expected to proceed.
- Dec 2020 Director reported- 47 patients – 3 on trial. NHSCT-20, BHSCT-17, SEHCT-8, SHSCT-1, WHSCT-1
- April 2021- Number of patients noted as 43 - 2 on trial resettlement and 1 on extended home leave. Expect another 5 discharges of BHSCT patients in the next 6-months by September 2021.

The Executive Director of Social Work reported satisfactory compliance with requirements specified in the Delegated Statutory Functions Scheme of delegation. The DSF report- noted 6 successful discharges and further 5 on trial resettlement with plans in place for a further 16 resettlements. The report noted a lack of community placements for LD impact on delayed discharge.

- Nov 2021- Director for strategic development updated on planning for On-Site business case.4 patients meet criteria. Outline specification drawn up and shared with capital panning team. Design team secured to complete feasibility study of the MAH site. Steering group has held 4 meetings.
- January 2022- Director update- 39 patient- 4 on trial and 1 on extended leave only 2 on active treatment. Chairman sought clarification on timeframe for the On-Site resettlement business case. Director reported that the timeframe for the On-Site scheme was 2024/2025. Further business case to be developed for forensic scheme- Requires identification of appropriate site.
- BHSCT's Delegated Statutory Functions report 2021/22 lacked scrutiny from Trust Board. It is of note that BHSCT reported that resettlement plans were in place for 15 patients and no plan in place for 1 patient.

7.2.5 Analysis of the regular updates to Belfast HSC Board and through the Delegated Statutory Function reports in regards to progress on resettlement, highlight the repetitive narrative based on plans in the early stages of development which were not robust enough to provide assurance in regards to projected discharge dates.

7.2.6 Whilst the Chairman of the BHSCT sought clarification on timeframe for the On-Site resettlement business case on 1 occasion and Director advised that the timeframe for scheme completion was 2024/2025, this appears to have been accepted rather than discussed or challenged.

7.2.7 BHSCT's dedicated resettlement team was funded for 2 community integration co-ordinators and a Social Worker to develop Essential Lifestyle plans. The Social Work post and 1 of the coordinator posts are vacant. A senior manager post established to review SEA's and develop an action plan on the lessons learned is also vacant.

7.2.8 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration

of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

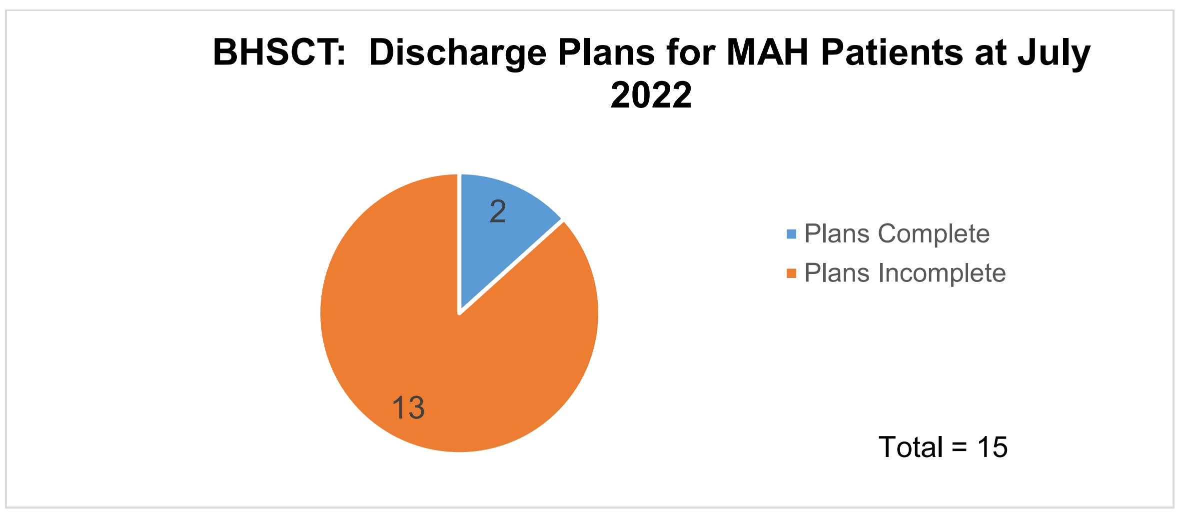


Fig 8

7.2.9 The review team considered in detail how the Trusts developed plans, proposals and accommodation services to meet the aggregated needs of this group as identified through their individual care plans in Chapter 8.

7.3 SEHSCT - Resettlement plans

7.3.1 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and 6 in- patients at 11th July 2022.

- The Trust was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and The Trust is now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for four patients appear to be realistic and deliverable. The Trust plans to discharge two patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from one patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and one young person who transferred from a children's facility.

- SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH discharges given the long lead in time
- It is of note that one SEHSCT patient has been on extended home leave with an extended support package from March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had one patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

7.3.2 The review team have used the Care Quality Commission - Brief Guide; definition that a discharge plan needs to have an identified care provider, an address and a discharge date to be agreed as a discharge plan. The review team used this definition to assess the robustness of the SEHSCT updated discharge plans. SEHSCT has a confirmed placement at Mallusk scheme for one patient with discharge expected in August 2022. The Trust has commissioned a nursing home placement for one patient with discharge date in August 2022. SEHSCT expect an additional patient to transfer to a specialist facility in the Republic of Ireland with discharge expected by September 2022. Three of the SEHSCT 6 patients have robust discharge plans and imminent discharge dates. A plan is in development for one patient and 2 patients do not have a robust plan.

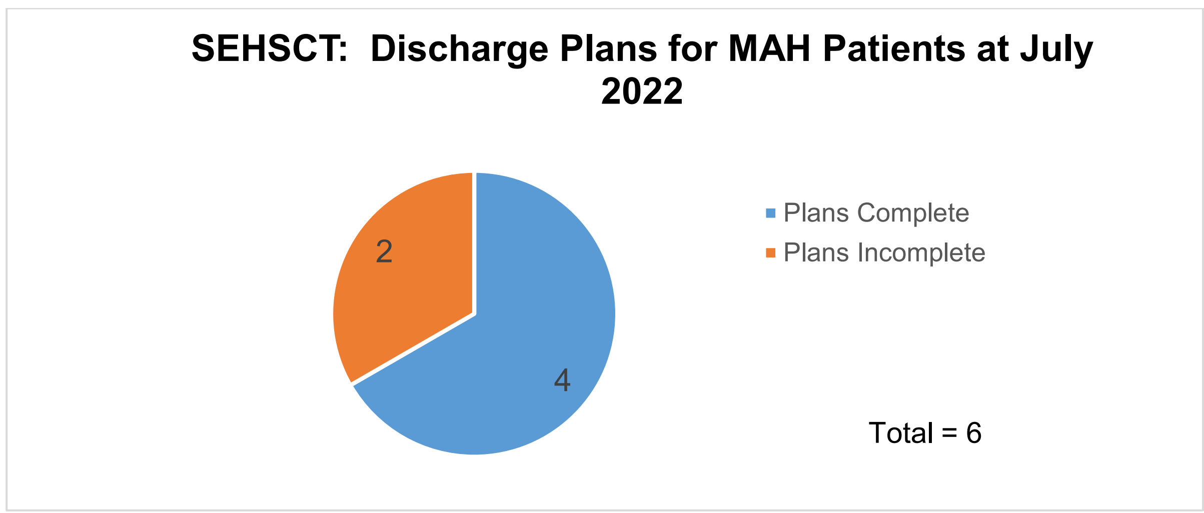


Fig 9

7.4 Northern HSC Trust – Resettlement plans

7.4.1 Historically the NHSCT has been reliant on hospital admission resulting in the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had nineteen delayed discharge patients in

Muckamore Abbey Hospital, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

7.4.2 The Northern HSC Trust's discharge planning was based on two new build schemes and a number of individual bespoke placements. The Northern HSC Trust was reliant on the Belfast HSC Trust delivering the On-Site scheme for one patient and the forensic scheme for one patient. The NHSCT has robust plans in place for 6 NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023.Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all three Learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of their patients from Dorsey and Lakeview Hospitals. In summary the Northern HSC Trust has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work for the Braefields scheme moving the handover date from end April to end August 2022.

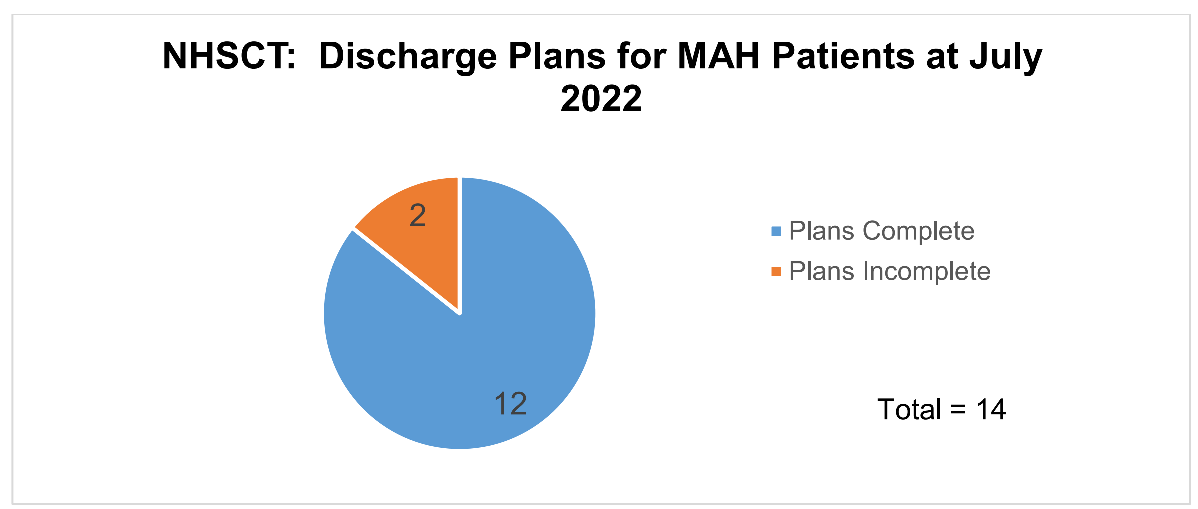


Fig 10

Key findings; the analysis of the review of Individualised care planning has highlighted a number of concerns and themes

- HSC Trusts were not responsive to data requests with responses missing deadlines and monthly performance monitoring templates not being robustly completed with key data missing or not updated.
- The narrative from HSC Trusts was repetitive and had not been sufficiently challenged by HSC Trust Executive teams, Trust Boards or the HSCB/ SPPG resulting in significant delay in identifying and challenging the lack of progress.

- Proposed discharge plans were not assessed against an agreed definition for a discharge plan, namely that a plan requires a confirmed care provider, confirmed scheme address and confirmed estimated discharge date to be agreed as a robust discharge plan.
- HSC Trusts were asked by the review team to validate the data supplied by RQIA and Supporting People and provide additional data on housing with support placements not captured in the NIHE and RQIA data sets. A questionnaire was developed by the review team to collate data from HSC Trusts to establish a regional supply map. The response from HSC Trusts was poor and not reliable. The HSCB/SPGG completed an exercise in 2020 to complete Needs assessment for Housing with Support. The variation regionally in demand reflected the poor quality of the information returned by HSC Trusts based on a range of interpretations of the questions.
- There is a need to get back to basics to ensure effective person centred planning and collaboration with all relevant stakeholders in the development of discharge plans. There appeared to be a lack of dialogue between HSC Trusts and providers to share the lessons learned from failed placements. The learning from trial placement breakdowns should inform discharge planning and will only be achieved through an integrated care approach based on partnership and collaboration.

Recommendations

- SPPG needs to strengthen performance management across the HSC system to move from performance monitoring to active performance management holding HSC Trusts to account.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment
- Consideration needs to be given to building highly specialist community based crisis response support teams to promote admission avoidance.
- A regional positive behaviour framework should be developed with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- Learning disability strategy / service model to be progressed by DoH should incorporate the evidence base for PBS and learning from other UK nations
- HSC Trusts should collaborate with all stakeholders to develop a resettlement pathway and operational procedure.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of

family carers as advocates for their family member is recognised and respected.

- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans

8. Operational Delivery of Care and Support

In the previous chapters we have talked about the strategic and commissioning framework for services, and also have considered the importance of good individualised care planning. In this chapter we need to consider the delivery of care and support and the experience of the individuals who have gone through resettlement and their families.

It is worth briefly revisiting what the current mapping of accommodation, care and support services looks like. There are 21 specialist LD nursing homes in NI offering a total of 606 places; there are a total of 48 residential care homes (15 statutory and 33 independent) offering a total of 546 places (123 statutory residential care places and 423 independent residential care places); and there are 149 accommodation based supported living schemes for people with learning disabilities offering a total of 1334 places across Northern Ireland.

8.1 Range of provision available:

8.1.1 There is a really impressive array of different types of homes for people with learning disabilities, and this diversity reflects the heterogeneous nature of the learning disability who will have a wide range of needs and wishes that need to be considered for each individual. This diverse picture also reflects significant variation in the cost of care, again dependent on a range of factors but primarily the needs of the individual and the staffing associated with those needs to ensure a safe and stable quality of care can be routinely delivered. In this context schemes which are designed and very bespoke to the particular needs of an individual will be higher than for those living in group living environments, where there may be ‘economy of scale’ factors to reduce the care costs. There has to be a recognition that for some individuals living with other people poses too significant a challenge and their needs can only be met in living alone situations, although there is always a need to ensure that these individuals have access to social relationships and community interaction as appropriate. Some providers have moved to try some innovation through congregated settings, but with separate living accommodation.

Range of provision available throughout Northern Ireland

Fig 11

8.1.2 The broad thrust within the Bamford Review had been towards smaller group living options, and away from large congregated community settings. The bar chart below shows the spread of size within accommodation-based supported living schemes funded through Supporting People and HSC funding agreements, and the general trend is in favour of smaller schemes. Whilst this is a welcome change of direction the emerging policy and strategic positions in relation to both learning disability and adult social care within Northern Ireland will need to address the sustainability of funding as demand increases linked to the demographic changes that we can expect for this population.

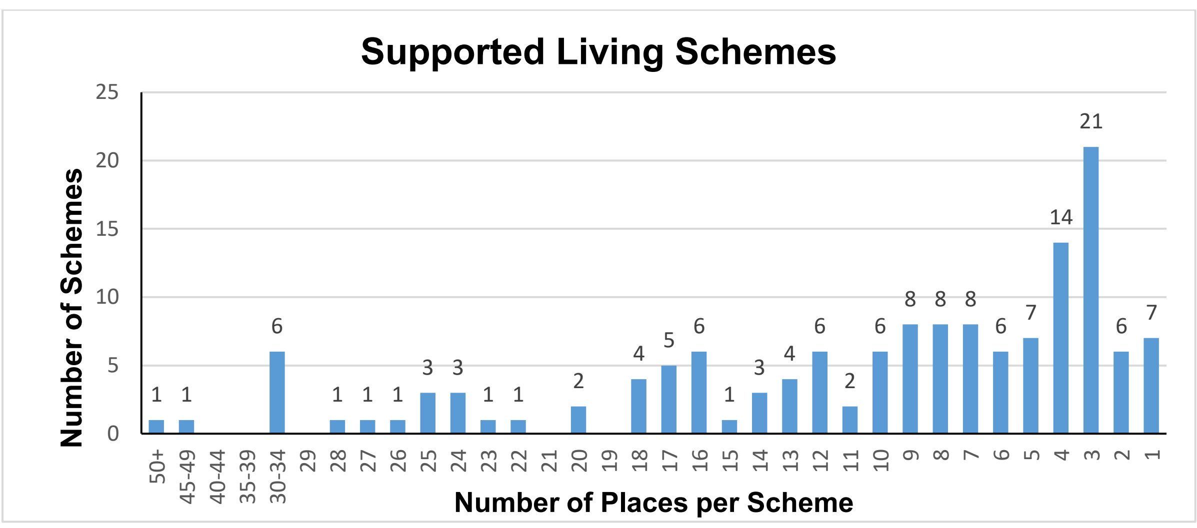


Fig 12

8.1.3 It is also important to recognise that within the independent sector it is highly probable that in the current population of residents and tenants within their settings that there will be individuals with similar needs profiles to those individuals who are awaiting resettlement from hospital. The sector has already demonstrated a readiness to meet the needs of individuals with complex needs often relating to co-morbidity of learning disability and mental health issues along with behaviour that can challenge. We heard several success stories which should be a strong foundation for understanding what works well for this group of especially vulnerable individuals.

8.2 Workforce

8.2.1 It is fair to say that across all stakeholders workforce was the single biggest concern, both in terms of the existing and future provision. Providers and NISCC as the regulator of the social care workforce expressed concern about the continuing need to develop a skilled and stable workforce across the sector. The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.

8.2.2 The models supporting the development of many of the new schemes are psycho-social rather than medical. Therefore the workforce will need to have skills in the delivery of psychological and social interventions, along with an understanding of the need to re-refer to specialist clinical services as and when appropriate. Most providers were now adopting Positive Behaviour Support as central to their service offer, although we heard concerns expressed by the

Royal College of Psychiatrists about the 'fidelity' of this approach which was often variable in both delivery and positive outcomes. There was certainly some anecdotal evidence to suggest that in some settings some of the least qualified and experienced staff were working with some of the clients with most complex needs. This sometimes resulted in poor continuity linked to high turnover of staff.

8.2.3 However the workforce issue was also a mixed picture. Some of the more established providers with a longer track record of service provision had better ability to recruit and retain staff, and some of the not for profit organisations had also recruited specialists in psychology or positive behaviour support to provide consultancy and support to their own provision. We also heard some providers describe how they had expanded the skill base within their teams by recruiting professionals from other disciplines such as teaching or youth and community work. Similarly we were impressed that some of the private providers described very stable teams, who were generally recruited from the local community with high rates of retention.

8.2.4 We have commented in an earlier section about the issues related to differential rates of pay, and particularly the disparity between statutory and non-statutory services in terms of Agenda for Change profiled pay in services provided by HSC Trusts. Whilst rates of pay are going to vary across the sector there needs to be some discussion within the sector to ensure that this isn't operated in a way that becomes a barrier to stability within the workforce. An integrated workforce strategy that looked at staffing across the whole landscape of learning disability services should be linked to the Learning Disability Strategy and Service Model, and should provide better learning and developmental opportunities as well as supporting greater mobility across sectors and roles. The review team are encouraged that MDAG has oversight of a regional workforce review across adult learning disability teams and services. This review has a wide scope of the learning disability workforce across statutory, private and independent sectors. A multi-disciplinary team has been put in place to undertake this important piece of work which is expected to complete in 2023; a survey has been undertaken to establish the baseline of the current workforce as of 31st March 2022.

8.3 Quality of Care within Services

8.3.1 Given the size and nature of the sector it has to be recognised that quality could be variable. However, there was certainly encouraging signs that would suggest that services were of good quality in many settings. RQIA have a responsibility to inspect registered care settings and in doing so seek the views of residents and staff. Generally in most registered care settings these are positive, with

positive comments about compassionate and caring staff in many settings. Whilst it could be argued that these may be more subjective than objective observations, RQIA are working with ARC and PCC through projects like "Tell It Like It Is" to ensure that there are a range of ways of accessing the views of people living within these settings and their families.

8.3.2 The review team were able to visit one particularly innovative example of a bespoke placement for a young man who was living with learning disability and ASD, and who was being supported to live on his own with 24/7 on-site support. He had successfully been transitioned back from a long term specialist placement in another part of the UK. The staff team supporting him were especially attuned to designing support appropriate to his needs and tolerances, as well as addressing the significant risks both within his home setting and when accessing the community.

8.4 Resettlement Process and Outcomes:

8.4.1 Broadly speaking the resettlement process could be split in to 3 phases – (1) pre-placement which included assessment and consultation to identify suitable placement opportunity; (2) transition phase which focuses on the planned move and immediate monitoring and support intensively immediately after placement; and (3) ongoing post placement support, including contingency plan to manage 'crisis'.

8.4.2 One area of concern was that the region didn't appear to have developed a regionally agreed resettlement/transitions pathway for people who were transitioning from hospital settings. Several stakeholders raised this as a concern. Families felt that they were insufficiently involved in developing these plans at times of a critical move. We asked the BHSCT as the lead Trust in terms of resettlement to provide us with the resettlement pathway, and after a gap of several weeks they issued us with a 'draft resettlement pathway' which we believe was produced without consultation with other Trusts, families or providers. Whilst it was good to see a willingness to develop an agreed pathway, we would have expected it to have previously been in place and to have gone through a co-production process. Consequently there was a great deal of variability to the quality of pre-placement arrangements and transition plans.

8.4.3 There were key issues which an agreed pathway and protocol could have resolved. Central within this would be where the primary responsibility for resettlement lay – especially what role the hospital multi-disciplinary team had in relation to the process relative to the role and responsibilities of the receiving/home Trust who would have on-going responsibility for supporting the

placement. We certainly were told of a concern that the hospital teams held an overly prominent level of sway in terms of choice of placement and the parameters of moves, including the extent to which 'leave' was extended for lengthy periods beyond the point where the individual had left the hospital. Several providers commented that the assessment of the client's needs provided by the hospital was sometimes not fit for purpose in terms of how they would devise a plan of care and support appropriate to the new care setting. Often the hospital had limited experience or understanding of how the client might be in other community-based settings. There was a general view that hospital perspectives could be overly risk averse, and rarely acknowledged the significant experience of the more established providers. The review team drew a conclusion that it was imperative that Community Learning Disability Teams/Services of the receiving/home Trust needed to take the lead during the transition phase and to act as an effective bridge between the hospital at the point leading up to discharge and the provider as they accepted the client.

8.4.4 Sadly several of the families that were willing to share their experience had gone through a process of placement break down, and we heard some harrowing accounts of how placement disruption was handled. However it is important to note that for many of these individuals and their families the system continued to support them and ultimately they found suitable new homes.

8.4.5 In terms of the third phase of post-placement support, again we heard of a very mixed picture from providers. Some providers talked about a lack of clarity between the roles of different teams.

8.4.6 Where systems described placements going well there were a number of key features which are worthy of note. The extent to which the 'new' staff supporting the client had an opportunity to begin to establish a working relationship and understand the individual and how best to meet their needs was an important foundation stone. Plans that had considered contingency if things started to go wrong were more robust, and in particular access to additional dedicated support from local Trust services at times when a crisis was emerging was particularly important. There is some variability between HSC Trusts in relation to the extent that they have been able to develop these specialist levels of support, although all are making moves in that direction. One provider described that their ability to support some individuals with very high levels of challenge and potential risk because of the responsiveness of the Trust services when they 'put up the flag'. In this scenario it was the strong and established partnership between the provider and the Trust services – clinical and commissioning – that gave them the resilience to support a number of individuals with the highest levels of need. In this situation there was clear evidence of effective communication, joint working and mutual respect and

support, all of which was focused on keeping the client at the centre of the process.

8.4.7 Whilst in all areas we heard about providers and local commissioners having engagement through contract review processes, there didn't appear to be well established broader engagement across the sector to support more effective partnership working. We felt that at a time when the health and social care system is committed to further development of integrated care systems, that there could be some work done here to support an integrated care pathway for these individuals with significant complexity of need.

8.5 Local Commissioning by HSC Trusts of Accommodation Schemes to address the needs of Individual Resettlement Plans

8.5.1 In chapter 7 the review team laid out what we found in relation to the evidence for good individualised care planning and the current level of practice. In order to find accommodation solutions for the individuals awaiting resettlement the Trusts needed at a local level to commission, either singly or jointly, new schemes that could meet the requirements for this clearly identified population.

8.5.2 There was distinct variation in relation to how effectively the development of new accommodation schemes was executed by individual Trusts.

8.5.3 Positively the NHSCT had worked well with a small number of trusted providers to develop several schemes which then had the potential to accommodate most of their remaining patients from MAH. At the time of the review this had ensured that business cases had been approved for social care and housing funding as appropriate, and the development of these schemes had reached completion of the buildings and were now moving to transition planning contingent on successful recruitment and staffing of the schemes.

8.5.4 Historically the NHSCT had historically been reliant on hospital admission resulting in them having the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had 19 delayed discharge patients in MAH, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

8.5.5 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with

discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

8.5.6 The Mallusk new build scheme was completed 2021 with 2 admissions to date with significant and unacceptable delay in the care provider recruiting sufficient staff to support further admissions to the remaining six places. This scheme will accommodate another 4 NHSCT patients and 1 SEHSCT patient.

8.5.7 The Braefields new build scheme for seven places has been developed to accommodate six patients from Muckamore and 1 NHSCT patient in Lakeview hospital. The NHSCT patient in Dorsey. Hospital is in the process of transitioning to a vacancy in a community scheme by end July 2022.

8.5.8 The NHSCT plans to discharge twelve MAH patients prior to end March 2023 to named and commissioned placements. These plans are viewed as robust – 6 to Braefields, 4 to Mallusk and the other 2 patients to named supported living and nursing home vacancies. The plans for the remaining 2 MAH patients are in development and not yet robust. The review team remain confident that the Mallusk and Braefields schemes will come to completion within the coming 6 – 9 months, and that this would allow the majority of the NHSCT clients to transition to their new homes. Whilst there had been some slippage in the time scale, their robust plans had supported effective review and senior leaders within the Trust engaged effectively with providers to challenge poor progress against agreed timescales.

8.5.9 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and six in- patients at 11th July 2022.

8.5.10 The SEHSCT, by working effectively in tandem with the NHSCT had been able to support the delivery of a number of schemes that would offer new homes to their remaining patients/clients. SEHSCT had the smallest number of clients remaining and relied on a mix of engagement with the collaborative inter-Trust schemes, and singleton or bespoke solutions. This allowed them to demonstrate that they had robust plans with a realistic potential of positive outcomes, although again recruitment difficulties for providers tended to be the limiting or constraining factor which delayed delivery.

8.5.11 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

8.5.12 SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH given the long lead in time, and therefore will be likely to meet future emerging need.

8.5.13 It is of note that 1 SEHSCT patient has been on extended home leave from MAH with an extended support package since March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had 1 patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

8.5.14 The Belfast HSC Trust (BHSCT) was an outlier in terms of its ability to successfully progress robust plans to deliver resettlement outcomes for the 15 patients who were their responsibility. However, it is worth making a few contextual comments in relation to the Belfast Trust's system wide responsibility. BHSCT had management responsibility for the provision of the hospital services provided at MAH, which dated back over an extended period of time. This meant that the Director and Co-Director in BHSCT responsible for learning disability services were balancing the ongoing delivery of the MAH hospital services, which faced significant safeguarding and staffing issues following the allegations of abuse, alongside the responsibility to support the resettlement not only of their own clients, but also of the patients in MAH who originated from other Trust areas. It should be noted that the HSCB had funded some additional dedicated staff posts within BHSCT to support the regional resettlement programme(detailed in chapter 7), and that the HSCB had provided substantial additional non-recurrent funding in light of the financial pressures associated with the heavy reliance on agency staffing within MAH staffing levels. The review team acknowledge that this placed the leadership team in BHSCT under considerable pressure, and it is to be regretted that this appears to have hampered their commitment to delivering the overarching resettlement requirements.

8.5.15 The BHSCT had through its planning processes proposed that the majority of its clients could be resettled through a number of dedicated new schemes. The primary focus of the new schemes was around 3 groups of patients. The first of these was patients who had been described as having a 'forensic' profile and required specialist provision specific to their needs. The second group was a small number of patients, most of whom had lived in MAH for several decades, and for whom it now appeared there should be a dedicated 'on-site 'provision' that would allow them to remain in situ but within a new or re-purposed accommodation on the hospital site. The third group were 5 patients, all from the BHSCT area, who had been identified for a new provision within the Belfast.

8.5.16 To meet the needs of these 3 distinct group of patients within MAH BHSC Trust's resettlement plans centred on 3 new build schemes in development since 2019. The 3 capital build schemes were planned to accommodate ten of the BHSCT patients. One patient for the On-Site scheme, 4 patients for the forensic scheme and 5 patients for the Minnowburn scheme which was a proposed development but not projected to be ready until at least 2025. The review team met with Northern Ireland Housing Executive's Supporting People leads in regards to the planning process for the Belfast Trust's Supporting People schemes in development and the strategic outline case (SOC) submitted for the forensic scheme and the process and timelines for full business case and delivery. Supporting People also provided update on discussions with BHSC Trust in regards to their plans for the Minnowburn proposal. The review team analysed the SOC submitted by the Trust and minutes of the Strategic Advisory Board meetings chaired by NIHE Supporting People Director. The review team noted confusion and drift in the range of schemes submitted by BHSCT as strategic outline cases. The SOC was drafted and submitted by a senior planning manager with extensive experience of previous resettlement schemes. When this manager retired it would appear that both organisational memory and experience were lost when he left, resulting in drift with SOC not progressing to full business cases as agreed.

8.5.17 At commencement of the review, the plan for the forensic scheme was a 12 place extension to an existing scheme, Knockcairn/Rusyhill. The original plan was for a twelve placement scheme to accommodate both MAH patients and BHSCT community clients and a strategic outline case (SOC) was submitted to Supporting People. Further analysis concluded that this design would not meet the needs of the remaining forensic population. Supporting People advised the review team that the full business case for the forensic scheme was anticipated in October 2019 but not received- Supporting People also highlighted that no funding from Supporting People has been ring-fenced therefore BHSCT will require to fund both capital and revenue funding.

8.5.18 BHSCT then asked a Housing Association to identify a suitable site for a new build scheme. Seven sites were identified however, location of the majority of sites were unsuitable for a forensic scheme due to proximity to high density areas. Preferred sites were identified in both the NHSC Trust and SEHSCT areas with the second confirmed as the most suitable. Given the inter-dependencies of the NHSCT and SEHSCT on this scheme all 3 HSC Trusts should have been collaborating on decision making but this was not the case, and the other Trusts were unaware of these proposals. Given the delays in progressing the business case, the NHSCT and SEHSCT are now scoping alternative individual placements with view to agreeing more timely discharge dates for their forensic patients.

8.5.19 The Belfast Trust Co-Director has now advised the Housing Association to take no further action to purchase a site pending further discussion in relation to needs assessment and current demand for a forensic new build scheme. The forensic scheme has been in development since 2019. Priorities have changed over the 3 years the outline case has been in development undermining the planning assumptions underpinning the proposed scheme. The process highlights confusion and drift and illustrates poor planning and delivery.

8.5.20 Minnowburn scheme for 5 BHSCT patients. The Minnowburn scheme requires disposal of a current BHSCT property/ site through Public sector trawl with an eight stage process and earliest delivery timeframe 2024/25 Whilst this scheme is in development it will not be ready until at least 2025. Alternative individualised discharge plans are now required given the long lead in time for project delivery.

8.5.21 MAH On-Site Provision: The picture in relation to the 'on-site' provision was particularly confused. The DoH had made it clear to Trusts that there should be consideration given to an on-site re-provision for those individuals for whom MAH had effectively been the only home they had known as adults. Whilst the letter from the DoH refers to a small number anticipated to be less than 10, at the point where the review team were considering the revised plans for individuals, only 4 patients had been identified as potentially requiring the onsite facility. The letter was clear that this provision should be separate from the assessment and treatment provision within the hospital. Four long-stay patients met the criteria identified; 1 BHSCT client, 1 NHSCT client and 2 SEHSCT clients. A project team was established chaired by the BHSCT Director and membership included SEHSCT and NHSCT representatives along with other key stakeholders. A design team was appointed to compete a feasibility study. In our meetings with senior staff responsible for learning disability services at the time in BHSCT there was a lack of clarity as to what type of provision was required, in terms of models of nursing provision, or social care and housing.

There seemed to be lengthy delays in establishing the feasibility of re-purposing some of the existing hospital estate and the associated indicative costs. In recent months due to the escalating concerns about the delay in the progression of plans for this provision by BHSCT the 2 other Trusts responsible for 3 of the 4 targeted clients have decided that the proposed on-site provision no longer represents the best option for their individuals and are pursuing other potential solutions. In light of this the BHSCT will need to consider how best to meet the needs of the 1 remaining patient who was in the cohort of 4.

8.5.22 Whilst all of these schemes had been in development since 2019 or earlier, at the point of the review in early 2022 none of these schemes had progressed beyond the most preliminary stages and given the dynamic position in terms of changes in the needs of the broader population the rationale underpinning the original cases for the schemes became unsustainable. In reality there were not credible plans in place for delivery of these schemes, and both capital and revenue funding had not been secured.

8.5.23 We have previously referenced the significant changes in leadership and planning roles, which was particularly apparent within BHSCT. This meant that there never seemed to be a maintained momentum for delivery of these proposed schemes through a rigorous project management approach. Given these difficulties and delays the projects failed to progress beyond the drawing board stage, and in the most recent discussions the other Trusts have indicated that they are pursuing alternatives to the proposed joint venture for a forensic scheme and on-site provision; they now want to consider separate provision on a smaller scale for their own clients. This has effectively meant that the considerable time and effort expended in the original proposals have not delivered and were ineffective. Additionally, it means that the assurances provided to the BHSC Trust Board regarding the robust plans being in place for the individuals concerned was not underpinned by realistic and deliverable planned schemes.

8.5.24 However, the recent ‘refresh’ of the senior operational leadership within the Learning Disability Team at BHSCT has brought some encouraging signs of a new approach. They are urgently reviewing all their plans, in the context of the rapidly changing picture as other Trusts review and accelerate plans for individuals. The additional catalyst for this revised approach and more rapid progress relates to the significant supply and financial pressures that the staffing situation in MAH is creating. In this context the BHSCT has shown a real willingness to look at re-purpose and re-design of some existing provision as an alternative to new build options. This could significantly improve the speed of the resettlement for the BHSCT residents who are patients in MAH, although these proposals are at a very early stage of consideration and have

yet to be tested fully in terms of feasibility, and acceptability to the individuals who will be offered these accommodation options, and their families.

8.5.25 Recent contingency planning due to staffing pressures at MAH and request to HSC Trusts to bring forward alternative plans to replace the capital schemes with lengthy and unpredictable delivery dates, has changed the discharge planning position for the 3 HSC Trusts with patients in MAH. BHSCT are responding positively to this new challenge and are scoping discharge options. The Trust has identified supported living schemes in the BHSCT area with under occupancy which may provide viable discharge options. These plans are in an early stage of development but show promise. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units (August 2018), highlights that a discharge plan needs to have an identified care provider, an address and a discharge date. The review team have used this as the basis for judging if the discharge options proposed by all HSC Trusts are robust enough to provide confidence and predictability in regards to timeline for discharge.

8.5.26 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

8.6 Lessons Learnt and Evaluation:

8.6.1 We know that many stakeholders within the overall system are committed to supporting a learning culture, which adopts a 'lessons learnt approach'. Organisations like RQIA have supported the adoption of Quality Improvement [QI] methodologies in supporting providers to promote continuous improvement within their services, and as previously identified the work that RQIA, ARC and the Patient and Client Council are doing within the 'Tell It Like It Is' Project are encouraging. However, we were disappointed that there didn't appear to have been any systematic evaluation of the experience of individuals who had been resettled, both successfully and unsuccessfully. It felt that there were opportunities to undertake some audit activity and also to consider whether

there is scope for pre and post placement Quality of Life measures to be applied so that there is some empirical evidence of the improvement in individual's lives. Although many people told us stories, both good and bad, of the experience of people during the resettlement process we didn't come across any evidence of this being properly documented, and consequently the voices of the people at the centre of this process often went unheard. There is undoubtedly potential for a more formal evaluation of the experience of those who have been resettled contributing to a better understanding of what works well and what doesn't.

8.6.2 On a positive note leaders and citizens across the system talked passionately about the need for better sharing of good practice models, and the need to ensure that the stories about the valued lives of people with learning disability must be communicated through a positive narrative available to the public and society at large in Northern Ireland. This laudable ambition is one that we believe everyone involved in this process would willingly support.

8.7 Recommendations

- The sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that it there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- HSC Trusts should urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning and promote good practice through a collaborative approach to service improvement.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better.

9. Safeguarding

In this chapter we will consider the legislation and policy relating to Adult Safeguarding in Northern Ireland, the learning from RQIA inspections, the findings from previous independent investigations of failures in the care provided to vulnerable adults and the views and concerns of family carers and their lived experience relating to safeguarding.

9.1 We have talked in previous chapters about the fact that the confidence of family carers in the HSC system's ability to Safeguard and protect people with a learning disability has been impacted significantly due to findings of abuse at MAH. We gathered evidence through our direct engagement with family carers which included family carers whose loved one has already been resettled and living in the community, as well as MAH family carers. All raised safeguarding as a significant concern with the review team. Family carers provided feedback to the review team about the actions they wish to see addressed in regards to their concerns about adult safeguarding and protection and their views and experiences will be explored later in this chapter.

9.2 It is important to set the concerns and expectations of family carers and the findings of this review in the context of Adult Safeguarding legislation, policy and practice in Northern Ireland.

9.3 A review of Safeguarding policy and practice was not within the scope of this review however, the review team analysed the findings from previous independent investigations of failures in the quality of care provided to vulnerable adults in Northern Ireland to inform our recommendations about individualised care planning and the commissioning and procurement of services to support discharges from Northern Ireland's Learning Disability Hospitals.

9.4 The recommendations arising from the 'Home Truths' report on the Commissioner for Older People's investigation into Dunmurry Manor care home (2018) and the CPEA Independent whole systems review into safeguarding at Dunmurry Care Home (2020) have resulted in a draft 'Adult Protection Bill' (July 2021) which will introduce additional protections to strengthen and underpin the adult protection process; provide a legal definition of an 'adult at risk' and in need of protection and define the duties and powers on all statutory, voluntary and independent sector organisations. An Interim Adult Protection Board (IAPB) was established in February 2021. It is clear to the review team that significant steps have been taken by the Department of Health to update legislation and policy in regards to adult safeguarding.in Northern Ireland in response to the learning from failures in care.

9.5 The Muckamore Departmental Assurance Group (MDAG) was established to monitor the effectiveness of the HSC system's response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff. The action plan monitored by MDAG, includes an action to complete a review of Adult Safeguarding culture and practices at MAH to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. This action is focused on safeguarding culture at MAH however, our engagement with the wider HSC and care providers highlighted variation both in practice and attitudes cross the Trusts. RQIA inspections of other learning disability hospitals in Northern Ireland also highlight ongoing concern about standards of safeguarding practice.

9.6 Current Safeguarding policy and practice is guided by; 'Prevention and Protection in Partnership Policy' (DHSSPS) 2015 and the adult Safeguarding Operational Procedures – 'Adults at Risk of Harm and Adults in Need of Protection' (HSCB) 2016. The policy highlights that adult safeguarding arrangements should prevent harm from happening and protect adults at risk. Safeguarding is a continuum from taking steps to prevent harm through to protection highlighting that safeguarding is everyone's business and not just the business of statutory safeguarding teams. The stories shared by family carers later in this chapter and in chapter 10, put the spotlight on psychological and emotional harm and fact that more could have and should have been done to prevent harm.

9.7 RQIA carried out a review of safeguarding in Mental Health and Learning Disability hospitals (2013) looking specifically at the effectiveness of safeguarding arrangements. A recommendation from the RQIA review was that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy framework. RQIA published a follow up report, Safeguarding of Children and Vulnerable Adults in MH/LD Hospitals in NI (2015) following inspection in the Southern HSC Trust.

9.8 The Bamford Review of Mental Health & Learning Disability recommended a new comprehensive legislative framework for mental capacity legislation and reformed mental health legislation for Northern Ireland. This has been taken forward by the implementation of the Mental Capacity Act (NI) 2016 which has a Rights based approach and brings new safeguards in regards to deprivation of liberty and consent. The Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and provides a substitute decision making framework. The Act is being implemented in phases. Phase one implemented from December 2019 included provision of Deprivation of Liberty Safeguards (DOLS') and a DOLS Code of Practice. DOH (April 2019) The Mental Capacity Act (NI) 2016 is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves and offer enhanced protections to people

lacking capacity. The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can. This legislation will change and shape practice across learning disability services with a focus on Best Interests. Decision making in complex areas such as the use of CCTV will be addressed in more detail later in this chapter.

9.9 Whilst progress has been made in regards to legal safeguards for decision making in respect of individuals who lack capacity and in regards to placing adult safeguarding on a statutory footing, incidents highlighting concerns about safeguarding and restrictive practices remain current in practice.

9.10 This is evidenced in an RQIA inspection report following an unannounced inspection at Lakeview Learning Disability Hospital between August and September 2021 which identified a number of matters of significant concern in relation to adult safeguarding and incident management. A further inspection was completed in February 2022 which found that progress had been made in a number of areas however, there had been limited progress with regards to adult safeguarding and incident management. The RQIA inspection report noted areas for improvement relating to adult safeguarding including a review of the use of CCTV to support adult safeguarding.

9.11 The 'Way to Go' report made a recommendation that In addition to CCTV's safeguarding function as a tool to prevent harm rather than as a means to ensure safe and compassionate care, CCTV should be used proactively to inform training and best practice developments at MAH CCTV needs to be considered This recommendation is included in the MDAG action plan and the BHSCT CCTV policy group continue to engage with stakeholders to reach agreement, on best practice in MAH .The review team were advised that Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site

9.12 CCTV was a central issue of concern for MAH families in the context of discharge planning. Some of the MAH family carers stressed the importance of CCTV in providing them with assurance. Families stressed that CCTV has been central to establishing abuse at MAH and that they hold significant concerns about CCTV not being in place in community settings. The review team were advised about one case where this issue created delay in progressing plans for discharge due to the Trust and the family holding differing views of what could be put in place. During engagement events with families, the review team were advised that some families see the need for CCTV as a consequence of their loved one being the subject of abuse at MAH and that maintaining similar monitoring in the community setting is an important bridge for these families. The debate on the use of CCTV between the family and the Trust in one case could be a barrier to discharge with potential to cause delay. CCTV played an important role in

recording potentially abusive behaviour by staff in Dunmurry Manor Care Home, Winterbourne View as well as MAH. The initial concerns were not initiated by CCTV but rather used to explore concerns raised by family which led to the identification of concerns. Given the importance family carers placed on CCTV, the review team reviewed the actions taken by RQIA to address this issue.

9.13 RQIA issued Guidance on the use of overt closed circuit televisions (CCTV) for the purpose of surveillance in regulated establishments and agencies (May 2016) The guidance was aimed at assisting registered providers in meeting the best interests of service users when considering the use of overt CCTV systems and reminds them of the requirements of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights-Right to respect for private and family life. The guidance states that CCTV should not be used in rooms where service users normally receive personal care and that a policy must be in place which outlines the provider's position on the use of CCTV. The RQIA also commissioned Queen's University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings (January 2020) which was commissioned in response to concerns regarding the quality of care and the potential for abuse in care home settings. The research highlighted that this is a complex ethical matter in the context of existing law and guidance. Expectations on the use of CCTV creates tensions between the needs of residents, family members and those providing care. The review completed on behalf of RQIA concluded that there was insufficient research evidence to support the proposed use of CCTV in care home settings.

9.14 Given the importance placed on this issue by some MAH families, the review team recommend further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.

9.15 The review team considered how the feedback provided by families in regards to their concerns about safeguarding should contribute to the discharge planning process and in supporting an individual through the transition process to a home in the community. Family carers were clear in their feedback to the review team that they have an active role in safeguarding by staying observant and alert to concerns and any change in their loved one's presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family. MAH family carers expressed concern and frustration due to the visiting restrictions required at MAH in response to the Covid pandemic.

9.16 The following patient story highlights a family's concern about the care arrangements and impact of the living environment on their son. The family highlighted to the review team that the focus at MAH has been on physical abuse of patients by staff but that in their case their concern is about psychological and emotional abuse.

'Family shared the story of their son who returned to MAH following a traumatic breakdown in trial resettlement placement after six months. His parents advised that they have not been advised to date that their son has been the subject of physical abuse, however, they highlighted that their son has suffered emotional and psychological abuse associated with both his in-patient stay in MAH and in regards to a trial resettlement placement. The family expressed concern about the quality of care in both the community placement and in MAH. Their experience of the community placement which had been a new build resettlement scheme was that it operated as a mini institution rather than to the vision of supported living that they had expected. The family were advised after the decision to end the placement was made by the care provider who did not think their son was compatible with other residents. The family experience of discharge planning and trial resettlement has not been positive and they reflected that the discharge planning was not effective and caused harm to their son due to the care provider not being in a position to meet his needs.
The family advised that since his return to MAH their son has regressed. The family expressed further concern about the impact of the Covid restrictions on visiting and in the reduction of the range of activities available which the family believe is detrimental to preparation for their son leaving MAH. The family talked about their experience of MAH being poor and their confidence in the HSC system significantly impacted.'

9.17 This story about the lived experience of a patient, highlights that transitions between services should be handled smoothly and systematically with attention given to ensuring the person's individual needs are well communicated between services. It also highlights that family carers should be seen as important partners in the care planning approach. The chapter on individualised care planning provides further case examples when communication between services was not as effective as it should have been. For individuals with behaviour that may challenge, it is critical that discharge planning is progressed in line with 'Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services' (2010) with a clear Safety Plan agreed and the family consulted about what is needed to safeguard and protect. The written care plan needs to detail any risks as well as what should happen in a crisis. We give further consideration to good discharge planning in the chapter on individualised care planning, highlighting the need for regional standardisation on the range of assessment and care planning tools used to ensure that individuals are safeguarded. A Person centred safety management plan should be central alongside a functional assessment and essential lifestyle plan and the family fully consulted and engaged in the resettlement planning process. We also highlighted that the risk assessment should be shared with relevant agencies and that the specialist knowledge and communication skills required to care for the individual should be defined and embedded in commissioning specifications and contracts.

9.18 Independent sector providers provided feedback to the review team on their experience of the adult safeguarding policy and procedures in practice which highlighted variation across trust areas. Care providers reflected variation in regards to thresholding of safeguarding referrals and variation in the attitude and support from different safeguarding teams. The review team recommend the review of Adult Safeguarding culture MAH is extended across community settings to address the experiences of key stakeholders including families and care providers.

9.19 Care providers also raised the use of restraint and the need to ensure appropriate focus on management strategies that enable preparation for discharge to the community. There has been growing recognition of the importance of reducing the need for restraint and restrictive intervention. DoH launched a public consultation on a draft regional policy on the use of restrictive practices in HSC settings in July 2021. It is critical that further review and analysis of incidents across all care providers in learning disability services is progressed to ensure learning and to inform the DoH review. The review team did not see evidence of effective sharing of learning from the analysis of incidents and SAI's with independent sector providers.

9.20 Feedback from family carers about safeguarding policy and procedures highlighted concerns that investigations were not progressed in a timely way which causes anxiety for the family. Trusts have highlighted workforce capacity issues. Given the impact of the ongoing PSNI investigation of alleged abuse at MAH and the evidence being provided to the Public Inquiry, more needs to be done to address the impact of delay in safeguarding investigations for families. Engagement with family carers highlighted that their concerns about safeguarding relate to current experience as well as the historic allegations of abuse which are the subject of ongoing police investigation and the focus of the Public Inquiry. It is critical that the experience of individuals and their family carers is heard and addressed.

Recommendations

In summary the conclusions and recommendations from this chapter are

- Further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- Contracts or service specifications for services for people with a learning disability should ensure that safeguarding requirements are adequately highlighted and that arrangements for monitoring are explicit.
- HSC should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.

- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.
- HSC Trusts should have arrangements in place to share learning about safeguarding trends and incidents with care providers.

10. Advocacy and Carer Engagement

This section will address the extent to which engagement strategies employed by HSC Trusts and collectively by the HSC system as a whole have been effective in supporting the delivery of the MAH resettlement programme; the extent to which families and patients were engaged in decision- making around resettlement and to what extent Advocacy support was provided.

Sincere thanks are owed to the family carers who engaged with the review team and so generously shared their personal experiences and stories. The families provided the review team with rich information about their lived experience which has shaped the findings for this review.

10.1 Participation and engagement with a wide range of stakeholders was central to the review however, the priority for the review team was to hear the voice of people with a learning disability and their family carers who have lived experience of delayed discharge and the resettlement journey. This was achieved in a number of ways;

- The review team issued a letter to every family with a loved one in MAH extending an invitation to contribute to the review of resettlement. Meetings were held at a neutral venue in the NHSCT, SEHSCT and BHSCT areas to bring families in each HSC Trust area together to hear their individual stories and common experiences.
- Some families did not wish to attend a public meeting but wished to meet with the review team. This was facilitated by home visits and zoom calls.
- The review team met with the 2 family carer representatives on the Muckamore Departmental Assurance group.
- The review team met with families of people who have already been resettled from MAH and whose placements have been successful
- The review team visited individuals with learning disability resettled in their community placement.
- The review team met patients and staff at MAH.
- The review team met with the Patient Client Council in regards to their role in providing Advocacy and supporting families involved in the MAH Public Inquiry.
- Meetings were arranged with Voluntary and Independent Care provider organisations who facilitated meetings with families.
- Engagement with RQIA - to learn about user experience from Inspections

10.2 Engagement strategies employed across the HSC

10.2.1 The Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 (ctrl click) applied a statutory duty of quality on the HSC Boards and Trusts. The 5 key quality themes which remain relevant to this review are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

10.2.2 The quality standards launched in 2006 (ctrl click) includes a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

10.2.3 The Bamford review recommended independent advocacy highlighting the need to support individuals to express and have their views heard. The principle of involving people in decisions about their care has been embedded in policy for many years. In 2012, the Department for Health and Personal Social Services (DHSSPS) launched a 'Guide for Commissioners- Developing Advocacy services' (ctrl click) introducing principles and standards. The DoH 'Co-Production Guide for Northern Ireland (2018) (ctrl click) recognised that co-production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

10.2.4 In the BHSCT's Serious Adverse Incident investigation report, 'A Way to Go', advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'. The report also acknowledges that 'episodic contact is unhelpful' however, did not address the question of how family members, where they exist, are supported to act as the primary advocate for their loved ones as active partners in their care.

10.2.5 There is significant learning from the Scottish Government's approach to citizenship and involvement. 'A stronger Voice' Independent Advocacy for people with Learning Disability 2018 (Scottish Commission for LD) (ctrl click) states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made

- Be involved in decision making processes
- Become more confident and able to self-advocate

10.2.6 The review team sought to establish the engagement strategies in place across the HSC system at a population and individual case level. It was evident that all HSC Trusts have a formal infrastructure in place at organisational level to meet their patient and public engagement duty through established committees. This review however, was primarily focused on the experience of individuals and families and the extent to which their voice was heard at individual case level and in influencing the policy and practice in learning disability services.

10.2.7 The Muckamore Abbey Assurance Group (MDAG) has 2 family carers as members representing the views of families with lived experience. At Departmental and HSCB/SPPG level there is limited evidence of engagement and involvement of service users and carers in the development of policy, however, ensuring that this is effective and that the experience of individuals is one of being respected and valued is challenging. The Covid pandemic significantly impacted on business as usual, however, there is limited evidence of meaningful engagement with individuals and carers prior to the pandemic or currently in the range of learning disability work streams led by HSCB/SPPG.

10.2.8 There is variation in the engagement strategies within learning disability services in each of the HSC Trusts however, all HSC Trusts are continuing to review and improve the arrangements in place.

10.2.9 This was evident in BHSCT who have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) (ctrl click) which includes a 'Communication and Engagement plan' the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers. The terms of reference for a range of engagement Forums were shared with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about transitions and accommodation. The BHSCT was the first Trust to establish a Carers Lead post to represent the views of people with lived experience of learning disability however, this post is now vacant. Whilst this is a positive step, further work and time is required to improve the number of families involved and engaged in the learning disability forums. There are only a small number of the MAH families actively involved in the MAH forum which reflects a significant level of disengagement due to

the breach of trust experienced by families following disclosure of abuse at MAH. The review team completed home visits with MAH families who have lost trust in the BHSCT and whose level of anger, pain and ongoing concerns about Safeguarding and Quality of service at MAH, highlight that a trauma informed and reconciliation approach is needed. The review team observed a number of occasions when engagement about a specific issue may have had a better outcome if the engagement and direct discussion with the family had been escalated to Director Level. Two discharge coordinator posts based at MAH had been funded to coordinate discharges across all patients. One of the discharge coordinator posts is now vacant. The resettlement team at MAH has reduced in size over the past year with an additional post-holder who had completed person-centred planning not filled. The NHSCT and SEHSCT lead the discharge planning for their own patients however, central coordination is required to arrange discharge meetings and to ensure that the range of information required from the MAH teams is available. The review team recommend that BHSCT considers the demand and capacity in the MAH resettlement team.

10.2.10 The NHSCT have also revised their approach to engagement and invited the review team to a public meeting organised by the Trust to engage their MAH families. A key learning point from this engagement event was the recognition that all of the families who attended in person on the evening had a shared experience of being involved in discharge planning for the new Braefields scheme. The families expressed the view that it is their perception that families have deliberately been kept apart and that the principle of stronger together should be embedded so that families can offer each other mutual support and identify common concerns and themes. This raises the need for the HSC system to recognise and value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.

10.2.11 The NHSCT strengthened their resettlement team recently, appointing a senior manager with oversight responsibility for monitoring progress against resettlement plans. The NHSCT is also in the process of appointing a lead Carers post to work in partnership with the senior management team to influence learning disability policy and service development. The review team met with NHSCT families who had a poor experience of communication however, there was positive feedback from a number of families about the relationship with the Trust's resettlement co-ordinator who has been in post for a lengthy period. The continuity of the relationship was valued by the families and highlights the importance of a key worker role, described to by families as the go to person for families trying to navigate across complex services.

10.2.12 SEHSCT has a long established Carers Forum for Learning disability who engage with the Trust in regards to policy and service development but also provide advocacy and representation of the views of people with learning disability and carers. The SEHSCT's in-patient population has reduced to just six patients whose age and range of needs are very diverse. A young person who transitioned a few years ago from a children's in-patient facility, a patient on detention though a Hospital Order with restrictions and an individual in his late 70's who has lived most of his adult life in MAH. The Trust's engagement with the remaining families is though the key worker, as the discharge solutions needed for the remaining patients are bespoke and highly personalised. The Trust had a dedicated post ensuring Essential Lifestyle discharge planning for all SEHSCT MAH patients transitioning to the community over the past years. This post is now vacant. There is evidence that using the tools of essential lifestyle planning is effective in developing a meaningful person-centred discharge plan. The review team recommend that all HSC Trusts embed essential lifestyle planning in the discharge pathway.

10.2.13 In summary, it is encouraging to see that the engagement strategies in all of the HSC Trusts have developed, but further time and effort is required to address the hurt and harm experienced by MAH families and to build the relationships and bridges needed to facilitate honest and mature dialogue and co-production. Overall across the HSC system, the voice of carers was not sufficiently evident within the leadership processes and there was limited evidence at all levels of effective co-production with carers.

10.3 The Voice of People in MAH - extent to which families and patients were engaged in decision- making around resettlement

10.3.1 Most of the families who attended the engagement meetings had previous experience of a trial resettlement that had broken down and were keen to share their experience of discharge planning and what went wrong.

10.3.2 There was not one voice but there were recurring themes from the review team's engagement with MAH families.

- Lack of trust, anger and families reporting invisibility of LD services
- Significant Safeguarding concerns
- Traumatic impact of abuse disclosures given the blind trust families had over many years seeing MAH as safety net
- not being involved or respected as expert by experience
- not being involved in relevant care planning meetings
- Experience of at least one trial placement breakdown

10.3.3 Some families talked about the culture and attitudes they had experienced over the years with HSC staff trying to 'persuade' them to accept a placement with a number of families referring to passive aggressive through to hostile approaches. Families referred to not being valued or acknowledged as experts by experience.

The following story of a mother's experience highlights the impact of culture and unhelpful communication styles;

10.4 A Mother's Story

10.4.1 Shared the story of a trial placement for her son which broke down within months. The family felt that the environment was appropriate however staff were not adequately trained or competent. Mother did not feel listened to or respected as an expert by experience who knew the triggers and warning signs that staff should have been attentive to. Family expressed the view that MAH did not provide enough information about relevant incidents on the care plan

10.4.2 When asked what needed to improve, the review team were advised by the family that resettlement needed to be accelerated and the following areas addressed;

- Better training for staff and assessment of competencies in key areas.
- An understanding of trauma and recognition of the experience and impact on families as well as their loved ones.
- Family carers valued as experts by experience and fully included in all decisions and meetings
- Better communication – Improvement needed to ensure communication is respectful and effective.
- Possibly some tools like a carers charter; an explicit statement of expectations and principles

10.4.4 The review team were advised that the family have experienced a breach of trust and confidence in the Trust and wider HSC system. The feedback provided to the review team confirmed that further work is required to ensure that all families feel effectively engaged in decision-making around resettlement and the monitoring of trial placements.

10.4.5 A number of families spoke to the review team about the importance of getting the culture, leadership and model of care right. The stories shared by families demonstrate the need for a tiered advocacy framework so that issues of complexity or dissension can be supported and facilitated more effectively

through independent advocacy. Families also told the review team that they have increasingly escalated to legal advocacy through the courts when the issues are systemic about failure to commission a service rather than about individual care planning.

10.5 Patient Story

10.5.1 The family confirmed that significant discharge planning had been progressed prior to the trial resettlement placement and expressed their disappointment and anger that the placement broke down within weeks resulting in their family member being returned to MAH without the family being advised in advance. The family had visited the trial placement daily and witnessed that the care staff were not competent to provide the care required. The family highlighted that the focus should not be on the number of staff required but on the culture, leadership and support the staff receive in addition to training and skills development. The family hold the HSC Trust accountable for commissioning the service and feel that HSC Trusts need to seek assurance that care staff have the appropriate competences.

10.5.2 The family believe that timely resettlement is in the best interests of their loved one and are actively involved in the planning for another trial discharge. The learning from the failed trial resettlement for the family was that they should be seen as a member of the multi-disciplinary team and involved in all meetings and decisions about care.

10.6 The Voice of People who have been successfully resettled

10.6.1 The review team met with a number of families whose family member has been resettled for some time. The narrative and experience of discharge planning and transition arrangements between MAH and the community are in stark contrast to the experiences shared by current families. It is of note that resettlement in the 1990's was strategically led and was progressed at scale with families reporting clarity about the process. This is best summarised through the story of a father who was very resistant to resettlement when the process commenced.

10.7 Lessons from what has gone well- A Father's story

10.7.1 The family of this young man were not keen on resettlement as they believed that their son was settled at MAH and that he was safe and secure. They were fearful of the unknown and had no experience or understanding of supported living services. The family advised that discharge was well planned and that

they had been able to consider a number of options. What has worked is that the care provider is open with the family who are made aware if their son's behaviour is changing. The staff identify the triggers that may result in deterioration and discuss with the family. The family advised the review team that their main concern prior to transition was safeguarding in the community. The family view the ability to visit their son flexibly and unannounced in his own home as providing then with real time assurance about his care rather than the formality of appointments. The family advised that the outcomes that demonstrate that resettlement has improved the quality of life for their son are numerous including the level of engagement he enjoys in activities in his own community, the fact that the parent/ child relationship has changed with their son supported to make adult decisions and personal choices about how he wishes to celebrate birthdays and Christmas. The family compared their son's life now to when he was in MAH and advised that he is living a fulfilling life and is central to his care planning. The family's advice in regards to what can be done to expedite or improve resettlement planning was quite simply 'Get it Done'.

10.8 Story of a young man with very complex behavioural needs living in Supported Living

10.8.1 The review team met with a young man now supported in a specialist supported living placement in the community having previously experienced admissions to MAH and other specialist in-patient facilities. The sustainability of this placement for a young man with very complex needs and challenging behaviour was stated by the care provider to be down to the partnership working between the care provider and the statutory learning disability team. The care provider uses a Positive behaviour approach with staff trained and competent in the methodology. The care provider highlighted that the responsiveness and wraparound support from the statutory team at times of increased challenge, actively reduces the potential for placement breakdown. The review team spoke to the young man and his care staff directly who described the full and active life the young man experiences and the support he receives to make personal choices. Additional positive outcome has been improvement in the young person's physical health with weight loss through a fun focused activity schedule. It was helpful for the review team to see an example of positive behaviour approach in action. The care staff reported that the model provides them with the support they need and they feel part of a wider specialist team.

10.8.2 This young man has needs equivalent too many of the patients in MAH who have been discharge delayed many years and this story is a helpful reminder that supported living models rather than new build bespoke are effective for

individuals whose behaviour can challenge. Voluntary sector care provider organisations stressed to the review team that the primary focus should be on a Positive behaviour approach and a skilled and competent workforce not just on the built environment.

10.9 Extent Advocacy support was provided regarding resettlement

10.9.1 The Review of Leadership and Governance at MAH recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

10.9.2 BHSCT has recently commissioned an independent review of advocacy services which is due to report by September 2022.

10.9.3 There are a number of Advocacy service providers engaging with MAH families. NHSCT commission independent advocacy services from Mencap for their families. SHSCT commission independent advocacy services from Disability Action for their families and Bryson House provides the independent advocacy service for both Belfast and SEHSCT. Families reported confusion about the roles of the various advocates involved, which is heightened when there is more than one advocate involved with the family.

10.9.4 The landscape has become more confusing for families with the Patient Client Council (PCC) providing direct advocacy support to MAH families. The review team met with the PCC Chief Executive and senior management team, who advised that PPC had been asked to provide support during the Leadership and Governance review feedback to families. In addition, the PPC provided a report on the engagement with current and former patients, families and carers regarding the terms of reference of the Public Inquiry. The PCC are now acting as the Independent Advocate for the Public Inquiry into MAH. As a result, the PPC has appointed a dedicated worker to build relationships with MAH families. The review team did not see evidence that the impact of the extended role for PCC on the long-standing commissioned independent advocacy services was considered or discussed between the various advocacy providers. Families reported that current arrangements are confusing and reported a lack of clarity about definition of advocacy, lack of clarity about roles and provided examples when an advocate from PCC and Bryson house were working at cross purposes. The situation was resolved but further review is required. The review of advocacy services commissioned by the BHSCT should bring forward recommendations to address the concerns raised by families.

10.9.5 Some families welcomed the relationship with the advocate involved with the family but struggled to provide examples when the advocate had made a difference in the resettlement outcome. There was confusion between a befriending and advocacy role with families stressing that it was the relationship they appreciated rather than the challenge function.

10.9.6 The following patient and carer story highlight the key issues raised by families in regards to advocacy. The strongest message was that family carers should be the first and primary step in advocating for their loved one.

10.10 Story of Long-Stay patient and experience of Advocacy

10.10.1 A mother met with the review team to share the story of her son who has been in-patient at MAH for some time. The story tells of a family who have maintained close contact with their son. The family have dreams for their son to experience community living with enhanced personal choices and less bound by hospital routines. However, a trial resettlement went badly wrong with the police being called by the care provider and their son being traumatically returned to MAH. The family believe the placement broke down because the care staff did not have the competencies to cope with behaviour that challenges. The family did not feel they were involved in care planning and expressed the view that they were advised by professionals rather than consulted.

10.10.2 The family talked about their experience with advocacy and felt strongly that the family are the strongest advocates in speaking up for their son. The family expressed confusion as there have been 2 advocates involved with the family and they are unclear about their respective roles. Family did not know why advocates became involved and state their view was not sought on the matter. The family advised that their experience of advocacy has not been positive and referred to the fact that the advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family expressed the view that advocates had agreed on occasion to do something but did not follow up. The family felt that they are the only ones in their son's life for the long haul and will continue to speak up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son.

10.10.3 The review team have reviewed the Terms of Reference for the comprehensive review of advocacy commissioned by BHSCT. The issues raised by families should be addressed by that review.

10.10.4 Other family carers reflected on current concerns about Safeguarding and the Quality of care in MAH. The families acknowledged that the Covid pandemic impacted on routine business but expressed concern that patient activities

being curtailed directly impacted on quality of life and preparing for transition to the community. Families also reported that the visiting restrictions implemented in response to the Covid pandemic raised anxiety about safeguarding arrangements due to visits being electronic or having to pre-book visiting with no access to their loved ones ward or living environments. Family carers feel they have an active role in Safeguarding by staying observant and alert to concerns and any change in presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family

10.10.5 Whilst there is relationship complexity across the wide range of stakeholders involved in the resettlement pathway, there is an urgent need to repair relationships and build trust. Families stressed to the review team that professionals talk about services but for the families it is their lives. The change that families want to see in the culture and attitudes across HSC services does not require radical reorganisation. The HSC Collective Leadership strategy (2017) (ctrl click) describes the values needed to promote shared leadership across boundaries and partnership working between those who work in HSC and the people they serve. Families stressed the need for a return to basics to achieve effective person centred planning and involvement of families in all meetings about care and decisions based on openness and respect. A regional one system approach and effective engagement and partnership working with family carers will be required to ensure the effective delivery of the final stage of the MAH resettlement programme

Recommendations

- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.
- Family members should be listened to and receive a timely response when they advise things are deteriorating
- Advocacy support should be available and strengthened at all stages of care planning-HSC Trusts must ensure that there is a clear pathway and clarification to explain the role of different advocacy services.
- HSC Trusts should utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families
- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences
- HSC Trusts should improve communication and engagement with families when placements are at risk of breakdown

- Families should be seen as integral to the care planning and review process and invited to all meetings
- A regional policy on the use of CCTV in learning disability community placements should be co-produced with relevant stakeholders.

11. Conclusions

Conclusions

11.1 The review team were determined from the outset of the review to ensure that the experience and voice of those with lived experience and their family carers informed the solutions and actions required to expedite resettlement .The review draws on the experience of people with learning disability who have been successfully resettled and those who have experienced breakdown and returned to MAH. The stories shared with the review team by family carers, brings into stark reality the impact that the allegations of abuse at MAH has had on family carers. In contrast, the stories shared by family members who have experienced successful resettlement, provide evidence of the positive outcomes and improved quality of life their loved ones are now experiencing.

11.2 It is important not to underestimate the challenge of planning for the resettlement of the remaining population whose needs are complex. The review team considered the learning from the policy and practice evidence base in relation to resettlement programmes across the UK and Republic of Ireland and a detailed analysis is contained in Chapter 4. Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. Actions that should be considered for Northern Ireland include;

- providing enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown;
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response-
- Implementation of a Positive Behaviour Service framework and provider engagement
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

11.3 Feedback from a wide range of stakeholders highlighted the need to refresh the strategic policy and service model for Learning Disability in Northern Ireland.

The above actions should be central to policy development but will require system leadership at all levels across the HSC.

11.4 The Learning Disability resettlement programme in the 1990s was successful overall, achieving a significant reduction in the long-stay population. The success factors appear to be that the resettlement programme was strategically and regionally led with ring fenced funding agreed across Department for Communities and the DOH with robust project management monitoring progress against targets. The current resettlement programme would benefit from a similar approach as it is currently a bottom up approach and lacks cohesion and direction. The data provided by the Trusts on progress on resettlement plans was not adequately scrutinised internally in the Trusts or externally by the HSCB/SPPG. The review team advised the HSCB/SPPG officers on actions to establish a more effective tracker tool to improve performance management.

11.5 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia and drift. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts involved in supporting individuals who are awaiting discharge from learning disability hospitals. The review team were pleased to see improved collaborative working led by the three directors within the past few months to seek solutions to the delayed discharge challenge and agree mutual aid in response to supporting MAH

11.6 The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services. The review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. Whilst the review team did see evidence of new initiatives in the BHSCT and NHSCT to build an infrastructure to support engagement with family carers, they do not yet reach the MAH families who have disengaged due to the breach of trust they have experienced. People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system.

11.7 Family carers raised safeguarding as a significant concern and the review team recommend further engagement with care providers, family carers and Trusts to discuss their expectations and concerns about CCTV.

11.8 The area of strategic commissioning also requires a refreshed approach. Strategic commissioning needs to be underpinned by a strong assessment of needs. It was a recurring finding at strategic and operational levels that needs assessment was not robust. The review team identified models of commissioning which could inform improvements in Northern Ireland. "Integrated Commissioning for Better Outcomes" was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. In Kent and Medway a new governance framework and an oversight board has been established to ensure that partners were accountable for commitments and performance. Accountability needs to be strengthened across HSC in Northern Ireland in regards to performance management against resettlement.

11.9 Engagement with independent sector care providers and Supporting People leads highlighted to the review team that knowledge and memory has been lost due to the turn-over in senior leaders most especially in BHSCT. Further work is required to build effective working relationships with key strategic partners to address barriers to resettlement.

11.10 The review team sourced data from RQIA and Supporting People in regards to the number of placements and schemes for learning disability and sought additional information from Trusts to form the basis of a supply map as seen in chapter 6. There does not appear to have been any analysis or strategic oversight to inform market shaping and this should be addressed by HSCB/SPPG and Trusts to inform strategic and micro commissioning.

11.11 Further development of social care procurement is urgently required and the review team recommends the development of a commissioning collaborative. Training and skills development on commissioning and procurement is required across the system.

11.12 The review team reviewed the care planning tools used by Trusts to support discharge planning. There is variation across the Trusts and the review team recommends that work is progressed to develop an over-arching resettlement pathway and standardise assessment tools to ensure that the needs of patients are considered as outlined in chapter 7. The learning from placement breakdowns highlights that discharge plans on occasion have not been sufficiently robust.

11.13 The review team scrutinised the current care plans for all the service users in MAH and critically analysed the actions taken by the responsible Trust to identify and commission suitable community placements. The analysis of length

of stay, the location the patient was admitted from and number of previous trial placements is presented in chapter 7.

11.14 The review team have assessed the robustness of discharge plans using the Care Quality Commission definition of a plan .Namely there has to be a named provider, address and confirmed discharge date. If this detail is not available the plan is incomplete. It is critical going forward that there is clarity and consistency in Trusts reporting on progress against discharge plans. The review team recognise that there are plans in development for some patients that show promise but in establishing a trajectory the system should only rely on plans that meet the definition outlined.

11.15 The South Eastern and Northern Trusts had taken steps some years ago to plan capital schemes that have already delivered or due to be operational in the next months. The BHSCT is an outlier in this regard with three capital business cases still in the early stage of development with the earliest date for completion 2025/26. The NHSCT and SEHST had been co-dependent on two of the three BHSCT schemes namely the forensic and on-site for a small number of their patients but are now pursuing other placements options.

11.16 As a result SEHSCT in-patient population at MAH has reduced to 6 patients. Robust plans are in place for 4 patients with no plan yet in place for two forensic patients. Two of the SEHSCT patients will be discharged by end August 2022 and an additional placement by end September 2022.

11.17 NHSCT has made good progress in delivering 2 new build schemes. Mallusk and Braefields which is due to complete end August 2022. NHSCT has taken additional steps to commission a number of individual placements in current schemes and plans to discharge 14 NHSCT patients by March 2023 This includes 12 MAH patients and the two NHSCT in out of area placements in Dorsey and Lakeview hospitals. NHSCT has 2 patients in MAH with plans not yet complete. the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefields scheme from end April to end August 2022.

11.18 BHSCT has been reliant on the 3 capital business cases providing for 10 BHSCT patients. This includes the Minnowburn scheme for 5 BHSCT patients and the Forensic and On-Site schemes. Given the long lead in time BHSCT is

now seeking alternative options to facilitate a more timely discharge. Whilst the BHSCT has adopted a refreshed approach with view to utilising available voids the plans are not yet complete. As a consequence only 2 of the 15 BHSCT patients have robust plans in place and 13 have plans that are not complete.

Reduction in Number of Patients in MAH between June 2021 and July 2022 and trajectory for Robust planned discharge by end March 2023

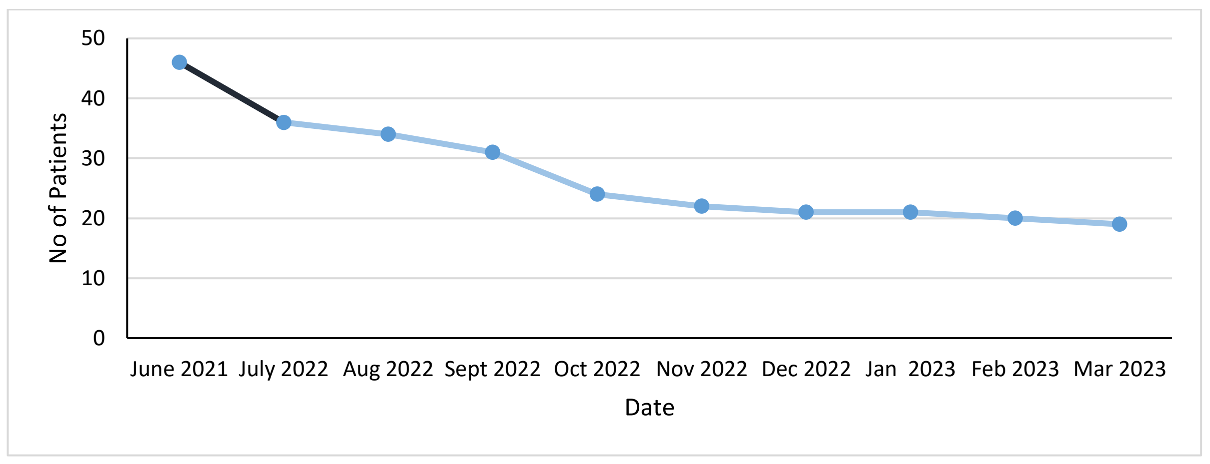


Fig 13

11.19 Fig 13 illustrates the discharge trajectory based on robust plans and robust timeframes. This is a conservative trajectory and the review team have confidence that further individual discharges will be progressed. It is encouraging to note that Trusts have responded to the recent challenge to develop contingency plans and that schemes in planning for some time now have confirmed discharge dates. The MAH population at 11th July 2022 was 36 in-patients, Fig 13 shows that the projected in-patient position by end March 2023 based on completed discharge plans is expected to reduce to 19 patients with potential for further individual discharges. Based on the analysis of the Trusts discharge plans against the Care Quality Commission definition of a discharge plan it is reasonable to assume that a further 17 patients will be discharged by end March 2023.

12. Recommendations

DOH

- The DoH should produce an overarching strategy for the future of services to people with learning disability/ASD and their families, to include a Learning Disability Service Model.

- The Learning Disability sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.

- People with a learning disability and their family carers should be respected as experts by experience and co-production built into all levels of participation and engagement across the HSC system.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on, to include audit of proved clinical and quality of life outcomes.

SPPG

- In the context of the overarching strategy the SPPG should develop a commissioning plan for the development of services going forward. This will include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment or deemed multi-disciplinary fit for discharge across all specialist learning disability inpatient settings in Northern Ireland.
- SPPG needs to continue to strengthen performance management across the HSC system to move from performance monitoring to active performance management, and effectively holding HSC Trusts to account.
- SPPG should develop a more detailed tracker tool to create a master database of discharges, readmissions and trends and establish a clear definition of a discharge plan to provide clear projections about the trajectory for discharge and progress over time.

- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract and guidance for specialist learning disability nursing/residential care.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland.

SPPG and Trusts

- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and explicit project plan for regional resettlement.
- SPPG and Trusts should develop a database of people displaying behaviours which may result in placement breakdown to provide enhanced vigilance and service coordination ensuring targeted intervention to prevent hospital admission and support regional bed management.

Trusts

- Trust Boards should strengthen oversight and scrutiny of plans relating to resettlement of people with learning disability/ASD in specialist learning disability hospitals.
- A regional positive behaviour support framework should be developed through provider engagement with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- HSC Trusts should collaborate with all stakeholders to urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of family carers as advocates for their family member is recognised and respected.
- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy at all stages of care planning and develop a clear pathway clarifying the role of different advocacy services.

- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences and utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families.
- The review team recommends a review of the needs and resettlement plans for all forensic patients delayed in discharge from LD Hospitals.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning about safeguarding trends and incidents and promote good practice through a collaborative approach to service improvement.
- Further consultation with individuals, family carers and care providers should be progressed to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- HSC Trusts should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.
- HSC Trusts should ensure that Contracts or service specifications for services for people with a learning disability have safeguarding requirements adequately highlighted and that arrangements for monitoring are explicit.
- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.

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Appendices

Appendix 1: The Review Team

The HSCB appointed a 2 person review team who were required to possess a strong understanding of health and social care policy and practice in Northern Ireland and Great Britain along with extensive experience in leadership roles directly related to health and social care.

The review team comprised:

Bria Mongan

Ian Sutherland

Appendix 2: **Biographies**

Bria Mongan and Ian Sutherland

Bria Mongan

Bria has significant Executive level experience within Health and Social Care organisations. Bria completed a Masters in Social Work in 1980 and remains registered as a social worker with the NISCC. Bria retired in May 2020 following a forty year career in Health and Social Care services working across all programmes of care. Prior to retirement, Bria was the Executive Director of Social Work and Director of Children's services in South Eastern HSC Trust. Bria previously was the Director of Adult Services and Prison Healthcare and was accountable for leading mental health and learning disability services including leadership in resettlement programmes. Bria is currently an associate with the HSC Leadership centre.

Ian Sutherland

Ian is an experienced leader in health and social care. He is a psychology graduate, who trained as a social worker in Nottingham in 1986, and completed an MSc in Health and Social Services Management at the University of Ulster in 1994. He has worked as a practitioner and senior leader in both Northern Ireland and England, holding three Director posts. His most recent leadership role was as Director of Adults and Children Services in Medway Local Authority, England. In this role he led partnership commissioning between health and social care in relation to delivery of the Better Care Fund objectives. He has served as a Trustee of the Social Care Institute for Excellence, and is currently an associate with the HSC Leadership Centre in Belfast.