MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Margaret Flynn
Date: 24 April 2023

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

The statement is made by me in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

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

Section 1: Qualification and Position

1. I am the Chair of the National Mental Capacity Forum in England and Wales; the commissioning editor of the J of Adult Protection; a director of All Wales People First; and a trustee of Anheddau Cyf.

Section 2: Modules – Topics to be addressed

2. Module 6(c) will address the report of 'A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go', published in November 2018.

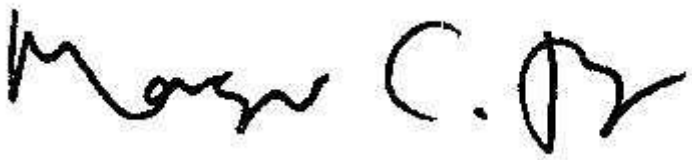
Section 5: Other relevant information

3. I was Chair of the Review Team whose work culminated in the Report.

4. I refer to a copy of the report marked MF/1.

Section 7: Declaration of Truth

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

Signed: 

Date:
24 April 2023

List of Exhibits (Margaret Flynn)

MF/1 A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, published in November 2018

A Review of Safeguarding at Muckamore Abbey Hospital

A Way to Go

November 2018

Margaret Flynn,

Mary Bell,

Michael Brown,

Bryce McMurray and

Ashok Roy

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THE REVIEW TEAM

Dr Margaret Flynn, Chair of the Review Team and Chair of Wales' National Independent Safeguarding Board

Mrs Mary Bell, parent and independent advocate

Professor Michael Brown, Queen's University, Faculty of Medicine, Health and Life Sciences

Mr Bryce McMurray, former Director of Mental Health and Learning Disability and former Executive Director of Nursing at the Southern Health and Social Care Trust

Dr Ashok Roy, Consultant Psychiatrist at Coventry and Warwickshire Partnership Trust and outgoing Chair of the Faculty of Intellectual Disability Psychiatry, Royal College of Psychiatrists

From the Review Team's experience of services elsewhere as advocates, practitioners, clinicians, researchers and managers, the members brought a wide range of independent perspectives and expertise in service provision for people with learning disabilities and autism.

The Review Team takes the view that people with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.

EXECUTIVE SUMMARY

1. A team of five was appointed to review safeguarding at Muckamore Abbey Hospital between 2012-2017.
2. The Review Team read patients' files concerning safeguarding incidents; associated documents; Northern Ireland's safeguarding protocol and procedures; and the Regulation and Quality Improvement Authority's (RQIA) inspection reports concerning the Hospital's wards. The Team met patients, their relatives, Hospital staff and managers.
3. During the Review, "Briefing Papers" were drafted and shared with the Hospital's managers, the Belfast Health and Social Care Trust (which commissioned the Review) and the RQIA. These feature in the Appendices. A draft report was shared with Hospital Managers, the Trust and the RQIA to ensure that it was factually correct. On 24 and 25 September 2018 the Review Team led a series of "feedback sessions" with a view to (i) presenting and discussing the findings with patients' families, the Hospital's staff and managers, and the Trusts responsible for placing people at the Hospital, and (ii) generating recommendations.

4. The Review Team found that:
    - Safeguarding events cannot be seen in isolation. Without exception, discussions concerning safeguarding gave way to patients' compromised lives at the Hospital, their chronic boredom and the failure to create and offer them high quality community services
    - Hospital patients are significantly likely to be harmed by peers
    - Irrespective of the considerable quantity of paperwork associated with safeguarding, the Review Team could not determine how closely Hospital practice aligned with the safeguarding protocol and procedures
    - The CCTV in the Hospital's Psychiatric Intensive Care Unit – with the highest staffing levels and ratios of qualified staff – shows patients being harmed by staff and yet no safeguarding referrals were made, and no members of staff spoke out
    - Patients' families are distressed and angry that nobody intervened to halt the harm and that even the possibility of patients being harmed was denied and deemed implausible by Hospital Managers and the RQIA
    - There was a culture of tolerating harmful and disproportionately restrictive interventions
    - Many families wanted to emphasise that harmful practices co-existed with skilled and compassionate practices and that there are excellent staff at the Hospital whose work is highly valued
    - The CCTV evidence triggered staff suspensions, an investment in viewing many hours of CCTV footage and acknowledgement that relations with patients and their families had to be restored
    - There is confusion about safeguarding "concerns" and "complaints"
    - The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic

- Over a third of safeguarding files state that patients have "a history of making allegations" which sacrifices patients' credibility
- 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
- Communications with families about alleged safeguarding incidents and potential investigations were vulnerable to being construed as seeking permission to undertake safeguarding investigations
- The routine (and discontinued) practice of involving the Police Service of Northern Ireland in all safeguarding discussions is bewildering
- Advocacy at the Hospital is not as uncomfortably powerful as it should be
- Place-hunting for Hospital patients is not working
- Leadership is distributed and not being used to benefit Hospital patients
- Northern Ireland's services are poorly equipped to support infants and children with learning disabilities, autism and complex medical challenges – whose families do not view the Hospital as their future
- The Hospital is not being used for short term admissions and treatment. It has been historically relied upon by Trusts as the "default placement" – placing distressed and chronically bored patients together. Safeguarding at the Hospital should be seen against this backdrop

5. The Review Team has identified the following lessons:
    - Safeguarding practice at the Hospital involves negotiating too many obstacles
    - The Hospital's senior managers must support staff who report harmful events and practices
    - Patients' and their families must be treated as equal partners and must be heard on a continuous basis. Episodic contact is unhelpful
    - The Hospital requires focus regarding its role and pace in the future of Learning Disability services in NI. This focus must be endorsed by all staff and managers, Trusts, the Department of Health and the Legislative Assembly
    - A life course perspective is required to understand and realise the aspirations of patients and their families.

6. The Review Team offered two recommendations underlining the importance of understanding that ordinary lives require extraordinary supports; and that a life course vision of services for people with learning disabilities and autism is required.
7. The "feedback sessions" endorsed the Review's findings and additional recommendations were identified – some of which were emailed after the events. These include repairing relationships and trust; challenging the custom and practice of seclusion; deploying specialist skills; leading values-driven transformation; clarity of services' purpose; and halting "default admissions" to Muckamore Abbey Hospital.

INTRODUCTION

1. During January 2018, the Belfast Health and Social Care Trust (the 'Trust') set out Terms of Reference for a review of safeguarding activities at the Hospital. The Trust asked the Review Team to identify the principal factors responsible for historic and recent safeguarding incidents at the Hospital. The team is independent of the Hospital.

THE TERMS OF REFERENCE

To undertake a level 3[1] investigation that:

2. Reviews the effectiveness of:
    (i) the identification and timely reporting of adult safeguarding incidents in Psychiatric Intensive Care Unit (PICU) and Six Mile in August 2017 & October 2017, and subsequent communication and reporting of these incidents between the Trust, Public Health Agency (PHA)/Health and Social Care Board (HSCB) and Department of Health
    (ii) adult safeguarding and the subsequent investigations in Muckamore Abbey Hospital from 2012 - 2017
    (iii) adult safeguarding protection plans in Muckamore Abbey Hospital
    (iv) the current advocacy arrangement in Learning Disability services
    (v) governance and quality assurance and controls in relation to quality, safety and user experience of care in Learning Disability Services from 2012 - 2017
    (vi) the implementation of previous recommendations following Serious Adverse Incidents (SAI), Adult Safeguarding investigations and Regulation and Quality Improvement Authority (RQIA) reports in relation to Muckamore Abbey Hospital from 2012 - 2017
    (vii) using the RQIA assessment definitions of Well-Led[2] assess the leadership within Muckamore Abbey Hospital to include:
        - Delivery of Safe, Effective and Compassionate Person-Centred Care[3]
        - Clinical supervision
        - Training
        - Multi-professional audit
        - Communication
        - Learning and improvement

[1] That is, a review of *serious adverse incidents* which *are particularly complex involving multiple organisations; have a degree of technical complexity that requires independent expert advice* and *are very high profile…attracting a high level of both public and media attention.* Section 5.3 of Health and Social Care Board (2016) *Procedure for the Reporting and Follow up of Serious Adverse Incidents,* Version 1.1

[2] That is, *Effective leadership, management and governance which creates a culture focused on the needs and the experiences of service users in order to deliver safe, effective and compassionate care*

[3] That is, *avoiding harm and preventing harm to service users from the care, treatment and support that is intended to help them. The right care at the right time, in the right place with the best outcome. Service users are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support*

3. Identifies areas of good practice both at Muckamore Abbey Hospital and in related services elsewhere with a view to proposing a programme of improvement and development associated with the outcomes of the investigation.
4. Advises on, with a view to consideration of, any other relevant matters that may arise during the investigation [4].

REVIEW METHODOLOGY

5. To orientate the Review, the Trust provided safeguarding files spanning 2012-2017 concerning 69 hospital patients; 61 RQIA reports of inspections of Hospital wards; 12 *Patient Experience Interviews*; *Adult Safeguarding: Prevention and Protection in Partnership* (Department of Social Services and Public Safety and Department of Justice, 2015), *Protocol for Joint Investigation of Adult Safeguarding Cases* (HSCB 2016), *Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection* (HSCB, 2016); and a history of the Hospital. In addition, the Review Team requested information concerning staff sickness absence rates; the staff recruited and those leaving; patient mortality; the referrals to safeguarding; seclusion reports; the governance structure; patient self-advocates and facilitation (from the Association for Real Change); the Society of Parents and Friends of Muckamore Abbey Hospital; and Advocacy meetings.
6. Between January and June 2018, the Review Team met with Hospital managers and staff: the Learning Disability Director, Clinical Director, the Head of Psychology Services, the Service Improvement and Governance Manager, Senior Nurse Managers, Service Managers, an Operations Manager, a Community Integration Coordinator, the Designated Adult Protection Officer, a social worker with responsibility for adult safeguarding, ward managers, the Lead Behaviour Nurse Therapist, the Day Services Manager, the Nurse Development Lead, Psychologist, Speech and Language Therapist, and the Parents and Friends Group, Hospital patients, advocates and facilitators and patients' relatives. Further, the Review Team met the Assistant Director of the Northern Trust, the Director Commissioner of the Belfast Trust and the Director/Commissioner of the Southern Trust, individuals responsible for reviewing the Hospital governance, Inspectors and the Assistant Director, Mental Health and Learning Disability of the Regulation and Quality Improvement Authority. The Police Service of Northern Ireland discussed its experience of safeguarding at the Hospital by telephone.
7. **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**.
8. Review Team members wondered about the information that the families of prospective patients to the Hospital might access, that is, information which does not arise directly from the Hospital. The answer is the independent inspection reports of the RQIA[5]. The Review Team could have compared and contrasted the RQIA's ward-specific recommendations and

[4] The Review Team was advised of matters which were outwith the Terms of Reference and these were directed to the Hospital's managers

[5] Reference to the RQIA's website sets out the role, methods, powers and responsibilities of the RQIA, https://www.rqia.org.uk/ (accessed 31 October 2018).

the resulting action planning of the wards. However, since **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. So, a different approach was negotiated which placed patient experience, safeguarding practice and the related topic of recording information, centre stage.

9. **The reviewers intentionally selected quotations to illustrate the typical as well as an array of examples from the Hospital wards' inspection reports. The reports proved to be a rich source of themes to which additional ones were added as they emerged**.
10. The Review Team watched *Muckamore Abbey in days gone by*[6] and three Review Team members watched 20 minutes of the CCTV footage which resulted in the suspension of six staff members during November 2017.
11. The Review Team's *Briefing Papers* were shared with Hospital managers and Board members once the content was agreed. These feature in the Appendices with the RQIA's feedback concerning the themes abstracted from its reports. Finally, the Review Team offered to facilitate multi-agency events including senior Hospital managers and Trust members to discuss the findings and test out potential recommendations.
12. The Review Team acknowledged the relevance of Mike Nolan's work concerning the *Senses Framework* (see Appendix 1). Since this has played an important role in raising the status, profile and quality of care environments for people with dementia there is merit in adopting its use to underpin environments in which everyone experiences the *senses.*
13. The Review Team's discussions - both person to person and email debriefing - and reflections on emerging Briefing Papers characterised its work. These were shaped by contact with patients and families – and a clear picture of the alternative opportunities and services required in Northern Ireland.

DESCRIPTION OF THE CASE

14. **During November 2017, it was reported in the media that staff had been suspended from Muckamore Abbey Hospital** (the 'Hospital').[7] Their "precautionary exclusion" enabled a joint adult safeguarding investigation of allegations of abuse of patients with learning disabilities. The media coverage acknowledged that there was CCTV data relating to the allegations and that six people had been suspended.[8] It was noted also that staff morale had hit "rock bottom."[9]

CONTEXT TO THE FINDINGS (and *other relevant matters*)

15. The findings are prefaced with this context because the provision and use of the Hospital have featured in the Review Team's meetings and discussions. That is, **without exception, the topic**

[6] https://www.youtube.com/watch?v=vQ6QjxB9UQQ (accessed 15 April 2018)
[7] http://www.bbc.co.uk/news/uk-northern-ireland-42058205 (accessed 30 January 2018);
[8] http://www.irishnews.com/news/2017/11/30/news/two-more-staff-suspended-from-co-antrim-hospital-amid-police-probe-into-ill-treatment-of-patients-1199982/ (accessed 30 January 2018)
[9] http://www.antrimguardian.co.uk/articles/news/61988 (accessed 30 January 2018)

of safeguarding gave way to discussions about ways in which services might establish conditions conducive to improving the lives of people with learning disabilities in the Hospital and in Northern Ireland.

16. The history of the Hospital is pertinent to this Review since it provides a basis for understanding the world of Muckamore Abbey. Appendix 2 reveals its wider relevance in terms of milestones and themes. **From its early expansion providing quasi-permanent living and training placements in a self-contained "village community,"[10] the Hospital's decline was associated with becoming rundown, understaffed, overpopulated and obsolete as a model of service provision. However, the Hospital survived closure headwinds** with familiar claims: the relocation of patients would be traumatic since they have long standing ties with the place; it would painfully revisit and reverse the decision of parents and families to secure a hospital placement; and community services are absent and/or poorly equipped to address the support needs of patients whose behaviour is difficult to manage.
17. **An undated "Business Case" for Muckamore Abbey Hospital envisaged a "core hospital…to provide in-patient element of the Assessment and Treatment of people with a severe learning disability and an additional mental disorder** as defined in the Mental Health (Northern Ireland) Order 1986." This heralded the closure of "the in-patient children's assessment and treatment unit (16 beds)…with an alternative service being re-provided in the community[11]…[and] a 115 bedded in-patient specialist psychiatric assessment and treatment service for people with a learning disability from the Northern and Eastern Health and Social Services Board areas and a Regional Specialist Treatment service…to meet Commissioning Board's target inpatient specialist assessment and treatment bed requirements as follows: Eastern Board, 70 beds; Northern Board 35 beds; Western Board 5 beds; Southern Board 5 beds." The Business Care referenced a "seclusion room with lobby" without elaboration.
18. Currently the Hospital provides services to between 80-90 patients, some of whom have lived there for decades. People's initial admissions were involuntary. During the 1960s the Hospital served many purposes, for example, a home for life; education, "treatment through training," respite for families, nurse training and teacher training. Five decades later, there are connections with these historical themes in terms of:
    - the Hospital's purpose
    - its adjustments to the demands arising from patients' support needs, including physical health care
    - the safe grouping of patients
    - the availability of crisis response and respite services in community settings
    - the destabilising effect of protracted uncertainty for patients, their families and staff
    - the severity of challenging behaviours being over-estimated, and the relevance of ordinary opportunities and accommodation underestimated.
19. **The law** is pertinent since it can safeguard and protect adults with learning disabilities from neglect and abuse. The Review Team sought to understand the context of references to

[10] https://www.youtube.com/watch?v=vQ6QjxB9UQQ (accessed 15 April 2018)
[11] http://www.belfasttrust.hscni.net/about/1615.htm (accessed 17 August 2018)

consent and mental capacity in information concerning the Hospital's safeguarding investigations. Northern Ireland is a distinct legal jurisdiction:

In the absence of specific adult safeguarding legislation, the last ten years in NI has seen the development of a range of policies and procedures which have determined the scope and nature of safeguarding practice*…Safeguarding Vulnerable Adults: regional adult protection policy and procedural guidance (DHSSPS, 2006), established the concept of a "vulnerable adult" and…included a reporting and investigation protocol and processes for monitoring professional practice. This was followed in 2010 by "Safeguarding Vulnerable Adults: a shared responsibility" (Volunteer Now 2010/2012) which provided advice and procedural guidance for voluntary and community sector organisations in recognising and responding to situations of alleged or suspected abuse…every incident requires a response; each response must allow for flexibility and individualised decision-making. Where an adult is deemed to be at risk,* [an] *investigation process is followed, progressing through stages of screening, investigation and assessment, implementation and protection planning, monitoring and reviewing and closure. Where a crime is suspected or alleged "The Protocol for the Joint Investigation of alleged and suspected cases of abuse of vulnerable adults" (Health and Social Care Board 2003,2009) provides procedural guidance"* (Montgomery and McKee, 2017, p201-202).

20. Adult Safeguarding in Northern Ireland has five ***underpinning principles****:*[12]
    (i) *A **rights-based** approach: to promote and respect an adult's right to be safe and secure; to freedom from harm and coercion; to equality of treatment; to the protection of the law; to privacy; to confidentiality; and freedom from discrimination*
    (ii) *An **empowering** approach: to empower adults to make informed choices about their lives, to maximise their opportunities to participate in wider society; to keep themselves safe and free from harm and enabled to manage their own decisions in respect of exposure to risk*
    (iii) *A **person-centred** approach: to promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings and, where appropriate, the views of others who have an interest in his or her safety and well being*
    (iv) *A **consent-driven** approach: to make a presumption that the adult has the ability to give or withhold consent; to make informed choices; to help inform choice through the provision of information and the identification of options and alternatives; to have particular regard to the needs of individuals who require support with communication, advocacy or who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in particular circumstances, for very specific purposes and always In accordance with the law*
    (v) *A **collaborative** approach: to acknowledge that adult safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners*

[12] *Adult Safeguarding: Prevention and Protection in Partnership* (DHSSPS and DOJNI, 2015)

across the statutory, voluntary, community, independent and faith sectors working together and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood. Working in partnership and a person-centred approach will work hand in hand (p8-9).

21. The *Adult Safeguarding Operational Procedures* set out the *main forms of abuse,* that is, physical abuse, sexual violence and abuse, psychological/emotional abuse, financial abuse, institutional abuse, neglect, exploitation, human trafficking/modern slavery and hate crime.
22. **The Mental Capacity Act (Northern Ireland) 2016** represents a potential approach to mental capacity and mental health law. Its origins reside in the Bamford Review of Mental Health and Learning Disability (2002-2007). The latter sought to combine service modernisation and a coordinated approach to legal provision, which in turn were informed by the principles of human rights and equality. However, the Act **has not been fully implemented** because the cost considerations remain to be determined (Harper, C. *et al* 2016). Although patients' mental capacity is a key element of the Hospital's safeguarding investigations, it cannot be determined from documentation how closely Hospital practice aligns with the spirit of the Mental Capacity Act (Northern Ireland).
23. The Review Team is advised that the compulsory admission of most of the Hospital's patients arises from the Mental Health (Northern Ireland) Order 1986.[13] However, **the Hospital is plagued by *mental health delayed discharges,* that is, although a clinical/multi-disciplinary decision has been made that a patient is ready to be discharged and the patient is safe to be discharged, the Hospital's delayed discharges are compromising its capacity to provide assessment and treatment**. While the reasons behind the delayed discharges are multi-factorial, patients subjected to protracted waiting for non-acute hospital provision are likely to deteriorate.
24. The Hospital's own *High-Level Analysis of Incident, Complaint and Serious Adverse Incident Investigations* spanned 1 November 2015-1 November 2017, and sought to triangulate Hospital records. The Analysis stated that, *"There were **4385** adverse incidents recorded…*
    - *Abuse of patient by staff, a total of **22** incidents*
    - *Abuse of staff by patient, a total of **3067** incidents*
    - *Abuse of patient by patient, a total of **1037** incidents*
    - *Abuse - Other, a total of **259** incidents."*
25. The outcome of the analysis, "*identified that Killead and Cranfield ICU have high levels of incidents of abuse and aggressive behaviour, particularly incidents where patients are abusive to staff. Erne ward recorded 8 incidents of staff abuse towards patients but when this was discussed with ward staff it was identified that one patient habitually alleges abuse by staff and these incidents are screened out and closed by the safeguarding process. The largest number of complaints[14] were in relation to quality of treatment and care."*

[13] https://rqia.org.uk/RQIA/files/4e/4ee9f634-be47-4398-afc9-906a20ff3198.pdf (accessed 19 April 2018)

[14] The complaints addressed by the Hospital since 2012 include: the negative effect of remaining a patient at the Hospital; cancelled appointments with a psychologist; delays in securing post hospital accommodation; RQIA recommended that windows should be covered – relatives state that bedrooms are now "like a prison;" comment of staff member; no support for family re discharge planning; the length of the safeguarding

26. These numbers illuminate:
    (i) the limitations of safeguarding referral data insofar as there is no backstory including reference to the links between combinations of patients/staffing/ward/hospital attributes and people's behaviour. The fact that a single patient may be associated with many incidents underlines the necessity of asking questions about context and data
    (ii) and the fact that patients at this Hospital share a common plight – the likelihood of being harmed by their peers.
27. The Review Team was informed that the high numbers of referrals to the PSNI (including those arising from peer to peer assaults) led to the Daily Mail describing the Hospital as the most violent location in the UK.

FINDINGS

"I'd rather be out and about in a place in the community" (RQIA, Donegore 2015).

The following sections begin with quotations from RQIA reports. The free-standing quotations were gathered during interviews and meetings. They are mostly unattributed.

(a) Adult safeguarding incidents in PICU and Six Mile

Cranfield can be a stressful environment to work in…many of the restrictive practices in use were not documented…and were not under regular review…completed restriction checklists were not available (Cranfield 2013);

11 patients had completed inpatient treatment and were waiting to move out…detrimental to individuals no longer requiring treatment…a step-down facility would allow patients to move out of ward to smaller, more home like environments (Six Mile 2013);

the rationale or therapeutic aim was not clearly documented…did not always justify the level of restrictive intervention (Cranfield 2013);

no bus runs or annual patient holiday…" they stopped the gardening programme without telling us" (Six Mile 2017).

We had no concerns until the CCTV came to light. It was disappointing that it was nine days before it was reported.

investigation process; delayed discharge; premature discharge; no [playground] swing for patient; the care at PICU; [historical] verbal threat by staff member; unsafe grouping of patients; failure to provide appropriate care and treatment x 7; information shared with relative without the permission of patient; relative not informed of an accident; patient left too long in wheelchair, clean laundry mixed with dirty laundry, low temperature in patient's bedroom; high temperature of ward; capacity to manage money; alleged abuse at the Hospital; poor communication with family re assault endured by relative; poor condition of bedroom; staff shortages x 2, inattention to a patient potentially eating cigarettes, the possibility of absconding; outcome of an abuse investigation not known to family/diagnosis sought; detention following a period as a voluntary patient; medication left out; different practice re administering medication at home and at the Hospital; patient made to clean faeces from a toilet; patient refused another consultant; patient's weight loss and eating habits

28. Between April 2012 and September 2017, there were:
    - 22 allegations of physical abuse (one of which also alleged psychological abuse) concerning staff working on **Cranfield**. Eight of these allegations were referred to the police. Two allegations concerned psychological abuse and one concerned sexual abuse. Eleven allegations were *screened out,* three were *closed* and the outcomes of others included, *SVA meeting…historical…happened during Physical Intervention… witnesses say did not happen…later retracted…unsubstantiated…protection plan put in place* for example;
    - four allegations of physical abuse concerning staff working on **Six Mile**, and one concerning psychological abuse. Three of the physical abuse allegations were referred to the police. The outcomes included, *closed… injured during Physical Intervention… screened out…investigated and closed…witness said it did not happen.*
29. The Review Team takes the view that individual patient files about safeguarding events implicating staff are a valuable paper-trail. They provide information about the allegation and safeguarding activities and processes which cannot be observed. Potentially they provide a behind the scenes look at the work and decisions of safeguarding investigators within specific contexts. The files have been assembled solely for the purposes of the review. Collectively, they contain forms such as: Adult Safeguarding Designated Officer Records; Decision to Close Adult Protection Investigation; Pre-Interview Assessment; Procedures for the Protection of Vulnerable Adult from Abuse and Exploitation; Witness Statement; Closure/Transfer Summary; Minutes of Initial Case Conference; Protection Plan Report; and Adult Protection Clarification Discussion.
30. However, there is little consistency across the files. The photocopied forms contain very many incomplete pages, for example, a section on Human Rights is rarely completed. Some forms contain signatures without reference to the role/designation of the signatory. Many of the files contain forms with handwritten information, some of which are illegible. Thus, **it cannot be determined how closely Hospital safeguarding practice aligns with *Adult Safeguarding Operational Procedures*.**
31. Appendix 3 sets out the principal findings arising from the safeguarding files and highlights those arising from Cranfield and Six Mile wards.
32. **The Review Team 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…it's not healthy// It might say "confidential", but you can guarantee that everyone knows everything in no time!* **This is a relevant backdrop since 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.**
33. RO14 [redacted]

RO14 [redacted]

34. RO14 [redacted]

RO14 [redacted]

[redacted]

[redacted]

[redacted]

35. Within a week of the CCTV evidence coming to light the process of suspending staff began and the Police Service of NI, the RQIA, the Chief Nursing Officer and the Department of Health were informed. Over the following weeks a team of social workers (not Hospital employees) scrutinised a sample of the CCTV evidence. At the request of the DH, the Hospital commissioned rotas of retired social workers and mental health workers to watch all the CCTV recordings (of over 5,000 hours) and cross reference events seen on screen with dates and times. The team of social workers cross referenced this information with individual patient care records, records of staff rotas and handovers, and other records to generate "historical" safeguarding referrals – albeit almost two years after the events occurred.
36. Although the Hospital promptly mobilised the Trust and senior DH officials, it was aware of the delay between the written recording of an incident and the response of a senior manager and informing the families whose relatives were placed on these wards. **So, from a position that appeared secure in terms of responding to allegations of harm to patients, senior Hospital managers were caught off guard.** The fact that no one had intervened to halt the harm and take charge was shattering. However, this time lag between the event and the response, as well as the inadequacy of the warning systems, are familiar to crises. The Hospital

might have discredited itself immediately by claiming that: "Everything is under control – it's business as usual". Relevant information was gathered very quickly.

37. All information had to be analysed with care and during this process the status of the recently installed CCTV was considered. The CCTV was contracted to go "live" during September 2017 and it is remarkable that senior Hospital managers appeared unaware that filming had commenced. The relatives of patients in the Psychiatric Intensive Care Unit are offended that events which came to light via the CCTV coverage were denied and even claimed to have been implausible. Such imprudent responses mean that new relations must be established with patients' families.
38. In addition to viewing specific events identified by rotas of viewers, the social work team scrutinised the associated records. For example, one patient had required hospital treatment having sustained fractures during physical restraint. The minutes associated with this "untoward event" stated that a series of physical interventions resulted from "behaviour influenced by the present environment" and concluded that the patient required a higher level of staff support and structure "to reduce the risk of boredom," that is, in the Hospital ward with the largest complement of staff. The minutes concluded "the staff involved in the process to be commended for collaboration and timely manner… [in which] witness statements etc. completed."
39. If these minutes were shared with the Hospital's executives and with the RQIA, it is disappointing that an intervention which resulted in operative treatment to re-set a fracture, was recorded as worthy of commending the staff involved and was not challenged. The physical interventions resulted in a patient's painful injury and yet there was no suggestion that the actions of the staff involved were so harmful that their practice of restraint required urgent attention. The way in which this mini-crisis was tackled and recorded by the Hospital conveys something of the corporate culture that governs communications.
40. Some records are missing. These include the records of staff who had been previously subject to disciplinary processes.
41. **The CCTV viewers have alerted the social work team to many examples of staff behaviour which resulted in the foreseeable suffering of patients**.[15]
42. The damage arising from such events lingers and will persist. However, the arrangements which gave rise to the damage are being faced. The responses of the Hospital and the Belfast Health and Social Care Trust were shaped by the *Protocol for Joint Investigation of Adult Safeguarding Cases* (2016), which *aims to provide a framework within which HSC Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm/abuse constitutes a potential crime* (para 1.2).
43. Necessarily the police investigation involved and continues to involve the scrutiny of the CCTV evidence and written records concerning events. It has required immersion into the circumscribed world of a learning disability hospital, for example whether the physical interventions seen on screen arose from accredited training. Additionally, the known distress-

[15] Examples have been removed for the purposes of the PSNI investigation

behaviour of some patients poses challenges for potential prosecution: it was *reported that it was a normal pattern for X to be distressed and challenging and then X would need…to vomit to aid his calming down. If this is normal behaviour it is difficult to claim that X suffered harm from being locked in room.*

44. In terms of patients' Protection Plans, these included staff suspension; reporting to the Nursing and Midwifery Council; reporting to the Trust's, *Nursing in Difficulty* – a means of tackling poor practice; being placed on restrictive duties; not being left in charge of a ward; weekly supervision; being supervised by a qualified member of staff when on duty; changing the times of monitoring visits during the night; "CCTV monitoring of 15 minutes per shift by senior nurses;" and ensuring that staff who were sleeping on duty were not on duty at the same time. Further, in the light of the inappropriate use of a "weighted blanket"[16] these have been removed from general use at the Hospital.
45. The files reveal the impact of the emergence of revelations and the decisions of the Public Prosecution Service on patients' families. One overwhelmed relative requested that information should be directed at a sibling on learning that what had happened to their relative did not meet the threshold for prosecution. Another family wondered if their non-verbal relative had "tried to tell" them about possible physical hurt by rubbing their arm or leg during visits. Discussing this with staff at the time, speculating that he might have been hurt, resulted in responses such as, "I don't think so. I wasn't on duty."
46. The social work team have negotiated with these families their favoured way of hearing about the events revealed by the CCTV. They are noted to be relieved that the staff associated with harmful practices are no longer working with their relatives. They are feeling disgusted, disbelieving, disappointed and angry – as well as guilty that they had imagined that their relatives would be safe at the Hospital. One family noted that, *I knew RQIA was rubbish, but I still had to use the procedure…I have been told every reason why what happened* [to my relative] *couldn't be true…once they realise that we are stirring the pot they get their act together…It's clear it's not a one off. There was a culture.*
47. The Review Team endorses the view about culture. **There was indeed a culture - a tolerated set of norms or work practices - which were harmful and disproportionate. It was shaped by the use of power, relationships and place in which the wards were "closed;" visitors – relatives as well as professionals - were advised whether or not they could visit due to "unsettled" patients; individual staff members were comfortable working with certain staff; and "cut and paste" records concerning the use of seclusion, for example, were not challenged.**
48. The fine-grain viewing, reading and analysis of the social work team has contributed to the Hospital's response. That is, as far as the police permit, information being shared with the relatives of patients who are known to have been harmed – and more generally a process of checking with 27 families[17] of patients who were placed in PICU and Six Mile Wards between March 2017 and January 2018. They were asked about their past and current *concerns about*

[16] Which should provide gentle, deep pressure touch
[17] At the time of writing

the standard of care, and how these *were addressed;* their experience of the ways in which staff have *spoken to or treated* their relatives; whether or not their relatives are *treated with dignity and respect;* the individuals to whom they would address their *worries…about anything in Muckamore;* what might *improve the quality and standard of care* at the Hospital; and the availability of staff to discuss their relative's care.

49. **The fact finding illustrates the juxtaposition of neglectful, harmful, disrespectful and valued practice**. For example, families want it to be known that there are some Hospital staff who conscientiously provide compassionate care and treatment: *kept my son alive// grade 3 staff go the full hog to meet needs// staff are fantastic.* Events were recalled that suggest critical pressure points for the Hospital, e.g. *lack of exercise and activity// relative putting on too much weight// clothing/money going missing// not protected from others// staffing shortages…busyness, long shifts* and the use of bank staff// *RQIA not fulfilling role// slow to attend to patients' physical health needs* and adverse *incidents//* a patient's *physical assault by staff had resulted in two court cases// the Ward Manager did not return calls// abuse between patients not taken seriously// quality would only be improved by closure// better planning for discharge.*
50. Fact finding with 18 of the 42 patients placed in PICU and Six Mile for the relevant period (21 from Belfast HSCT, nine from Northern HSCT, ten from South Eastern HSCT and two from Southern HSCT) hinged on their experience of being at the Hospital, the staff, the activities available, whether they felt safe and how the Hospital might be improved. It was noted that although some patients found it difficult to understand the questions, two people expressed frustration at being unable to leave and six were unhappy about the behaviour of other patients/unsafe grouping of patients, the majority were uncritical of the Hospital. Activities were valued when they were available, and one person acknowledged the help he had received to prevent self-harming.
51. Other assurance activities include maintaining patients' protection plans; sustaining links with patients' families; staggering the night-time monitoring visits to wards; recruiting two out-of-hours supervisors; increasing the availability of behavioural support nurses; enhancing the monitoring of the wards with unannounced visits; recording the start and end time of staffs' night-time breaks; increasing senior management oversight of wards; reviewing the staff who were suspended or subject to restrictive practice each month; offering these staff the support of Occupational Therapy and Psychology services; installing CCTV in all other wards; safeguarding training for staff and patients; monthly Assurance Meetings involving the Trust, the PSNI and Human Resources; hosting Memorandum of Understanding meetings for the Trusts, the PSNI, the RQIA, the Board and the Department of Health; releasing a media statement by the Trust, the Board and the PSNI; and, most recently, responding to the leakage to the media concerning the content of the CCTV.[18]
52. 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

[18] https://www.bbc.co.uk/news/uk-northern-ireland-44984924 (accessed 29 July 2018)

response. Senior Hospital managers took charge and the families of patients had person to person contact with Hospital staff. Moreover, the patients required information, assistance and respect. Viewing the extensive CCTV evidence has resulted in decisions concerning staff suspensions, questions concerning the adequacy of internal and external scrutiny and renewed consideration of options for the Hospital's future.

53. **Inherent in crises is the task of looking for information. The social work team has highlighted, *inter alia,* that patients were not the priority of certain staff members; that the focus of the Psychiatric Intensive Care Unit was lost; that "most events" occurred during weekends and "never" on Tuesdays when audit visits and similar activities took place; that signatures were omitted from certain records; the power of certain unregistered practitioners; and that critical documents and records have been "lost." Although the viewing has also highlighted examples of sensitive and compassionate exchanges with patients, the durability and legitimacy of these are regrettably lost in the urgency of the harms endured**.
54. Such relevant information has emerged gradually. What Hospital managers have sought to understand are the overall dynamics that so quickly socialise staff into deprioritising the treatment, safety and comfort of patients. The recent challenge facing the Hospital because of the information leakage includes the fact that although it has taken charge, unknowns remain, that is, from the as yet unseen CCTV evidence. However, to date it has demonstrated openness and a desire to assist in securing criminal justice results at such a difficult time. Importantly, its specific actions are complemented with attention to the long term and necessarily this requires engagement with the external agencies. Muckamore Abbey is a regional Hospital and regional solutions are required to address the fact that "the majority of admissions are after hours" and it is just too easy to admit and re-admit patients.

(b) Adult safeguarding and investigations since 2012

> *Significant number of vulnerable adult referrals* (Ennis 2012);
>
> *increased number of incidents…not disproportionate* (Killead 2016);
>
> *no evidence that capacity to consent to care and treatment was being monitored regularly* (Cranfield 2014).

55. Between April 2012 and September 2017, the Hospital recorded 128 allegations concerning staff working on PICU, Six Mile, Killead, Ennis, Oldstone, Greenan, Cranfield, Mallow, Donegore, Moylena and Erne. Over 92 of these allegations concerned "physical abuse," and 102 (80%) concerned physical abuse combined with "institutional abuse, psychological abuse, verbal abuse, verbal and psychological/emotional abuse." **Thus, the most typical type of allegation concerning staff is physical abuse.**
56. **The language used by practitioners reflects that of the policy and procedures. However, language explains, and obscures and "concerns" are non-specific and barely capture the harms endured by some patients**. "Complaints" also feature in the safeguarding vocabulary

and this features in the Referral/Screening Information template, that is, *the victim has capacity to make an informed decision and does not want to make a complaint to PSNI/or the victim does not have sufficient capacity and the next of kin does not wish to make a complaint on their behalf.* Potentially this conflates the complaints and the safeguarding processes (see footnote 14). The Review Team questions how a complaint concerning safeguarding differs from one in relation to the quality of patient care and treatment.

57. **The Review Team was told that, *there is no monitoring of seclusion and, regardless of the policy, it seems to be the first option. We have scenarios of people who are not detained, who have capacity, who are being secluded – and there is no form of appeal…The seclusion room is not fit for purpose. It contains a chair…*** What information was provided to the architects concerning a "seclusion room with lobby?"
58. Hospital data for 2015 records 21 patients subject to 859 seclusion episodes with three people accounting for almost 90% of these. One patient was subject to seclusion on 78 occasions in a single month. During 2016, 20 patients were subjected to 575 episodes of seclusion, with two patients accounting for 55% of these – that is, two of the three people who were the most frequently secluded during 2015. During 2017, 15 patients were subjected to 616 episodes of seclusion with the same two people highlighted in 2015 and 2016 accounting for 75% of all frequent seclusions. One of these people was subject to 75 seclusions in a single month.
59. The Belfast Health and Social Care Trust's policy says, "Use of interventions are not seen as a long-term solution in the management of service user behaviour…" It is not clear why the practice persists for two people since their intensive use of seclusion over a three - year timeframe appears wholly disproportionate. The Team questions the prevailing assumptions concerning the use of seclusion. Was its use always a "last resort" and/or an unequivocal emergency? Current scrutiny of practice would suggest that the use of seclusion was not benign in all circumstances. The 20-minute viewing of CCTV evidence prompts the Team to question the adequacy of furnishing in the seclusion room and the physical comfort of patients placed there. How was the room designed to minimise injury? For example, is there protruding beading around the doors and windows?
60. Appendix 3 confirms that the allegations of assault comprise the lion's share[19] of safeguarding referrals. The allegations include hair-pulling, being pushed, thrown, nipped, scratched, dragged and bruised. However, the contexts and *factors precipitating referral,*[20] are generally suggested, e.g. *very unwell at present.*
61. **The statement, "Has a history of making allegations" features in almost a third of the safeguarding files**. Such an assertion risks compromising scrutiny of events since it potentially sacrifices people's credibility at the outset. Just over a third of the files highlight the implications of the allegations for staff, that is, they are most typically removed from the ward/working with the patient who made the allegation. As one file noted, "Has history of making allegations which is why two staff are always present." However, a relative has also

[19] The Review Team is cautious in providing specific numbers since the files do not permit specificity
[20] Required in the Referral/Screening information: Regional Adult Protection Procedures

countered, "makes allegations in frustration." Is it not possible that some patients have memories of previous events at unknown times which are resistant to forgetting and about which, no one took them seriously?

62. Layer onto the patients' allegations considerations of the mental capacity status of the patients and inconsistencies begin to emerge. **Around a half of the files referred to patients' mental capacity, however, it is not consistently clear how decisions concerning capacity have been facilitated or what they relate to** - as the following quotations reveal:

    Mental capacity regarding…? *has capacity//did not have capacity// deemed incapable…would have limited capacity// does not have capacity// patient not capable…does not take responsibility for actions nor does patient have capacity to consent// lacks capacity// has capacity in relation to some issues.*

63. Mental capacity is decision-specific and concerns the ability to decide about a matter at the time that the decision needs to be made. To adopt an "all or nothing" approach to mental capacity is unwise. It is unacceptable to assume dominion over another person without the facility for this to be questioned.

    Mental capacity re referral/interview/adult safeguarding: *not fit for interview// does not have capacity to engage in interview// does not have the capacity to be interviewed in respect of this matter// lacked capacity when interviewed// does not have capacity to consent to safeguarding process// deemed not to have consent at [resent to engage in the adult safeguarding process// would not have the capacity to make a complaint under the vulnerable adult process// does not have sufficient capacity re adult safeguarding processes…does not have capacity to consent to safeguarding processes// lacks capacity/ understanding to engage in vulnerable adult process// mental state poor – interview won't be appropriate at this time…advice sought re X's capacity to engage in safeguarding process…was deemed to have capacity but did not fully understand the process, including the court process// would lack the capacity to understand the purpose of the measures in place and the safeguarding process// does not have capacity to manage money…does not have sufficient capacity to make Achieving Best Evidence statement.*

64. Do patients routinely receive independent help and support with understanding issues and putting forward their views, feelings and ideas? There are no documented occasions when patients have been offered enough information to make specific decisions. In fact, **there is an example of a patient being denied the opportunity to attend "Keeping Yourself Safe" training. Since this is arguably one means of assisting patients to understand abuse and the ways it may be prevented, it appears unreasonable**.

    Contingent on clinicians' decision-making: *will be given the opportunity to engage in adult safeguarding if deemed by the psychiatrist to do so// unable to engage in vulnerable adult process due to deterioration in mental state…capacity and understanding is dependent on patient's mental state// with patient's limited understanding it is very unlikely that Dr will think patient has capacity to engage in the investigation process//*

due to the extreme detrimental effect this would have…does not have the capacity to be interviewed.

65. **Even though the Mental Capacity (Northern Ireland) Act (2016) remains to be fully implemented, it appears extraordinary that clinicians are determining whether there should be a safeguarding investigation**.
66. **A great deal is expected of patients making allegations, most particularly if they anchor an event to a time or date, for example, it was noted of one patient that he was "an unreliable historian." Their specificity is taken at face value, for example, one file noted that an event could not have occurred because the member of staff was "not on duty on the night in question." Is it not possible that some patients with learning disabilities have a limited understanding of dates, days of the week and the passage of time?**
67. There is an example of a patient stating that a peer's allegation was untrue because they were together, and the alleged event did not happen. Similarly, staff members who witness or a party to an event that becomes the focus of an allegation are instrumental in either escalating what has been witnessed to a senior manager and/or contributing to the determination of whether a patient was harmed by providing an account of events. There are trauma-specific memories which carry influence over time. Although the corroboration of others is consistently helpful, there must be some consideration of the possibility that *something* has happened, perhaps in a context like that of the allegation.
68. Delays in investigating an allegation may result from the Hospital's protocol, that is, "As per the Hospital protocol, where safeguarding concerns are raised regarding a staff member and the patient is not a Belfast Trust patient, these are referred out to the relevant community team."
69. **Patients' families appear to have a critical role in converting an allegation into a safeguarding investigation** as the following quotations reveal:

    Father happy with the management plan of allegations…satisfied that no assault occurred// mother does not wish to take further action// mother does not wish to take it any further…does not wish to make a complaint to PSNI on X's behalf// parents have not been informed due to …unacceptance of "allegations"// mother does not wish to make a complaint// family do not feel there are grounds to progress a police investigation// mother did not feel it was a big issue// relative wants it investigated// NOK aware of circumstances and not raising concern// family *do not wish police involvement//* relative *rang PSNI very anxious and influenced by recent media attention…was reassured about X's care…does not wish to have the matter investigated by the police// relative stated "this is X's usual avoidance behaviour"//* family *was satisfied that no abuse occurred.*
70. It appears that **although families are likely to be informed of their relative's allegations or the harm experienced by their relatives**. However, **such communication is vulnerable to being construed as seeking permission to undertake a safeguarding investigation**.
71. Three files refer to thresholds, that is, *did not meet the threshold of a safeguarding investigation given sufficient evidence that this did not occur// referral does not meet the*

threshold of an adult in need of protection and can be screened out// This does not meet the threshold of serious harm under new policy.

72. **The terms "screened out" and "rejected," are stark and yet commonplace in the files**. It is not clear that they were succeeded by risk assessments of individuals and/or specific wards. For example, one patient made 18 allegations when he was on Erne.
73. **Three files refer to whether an allegation is "RQIA notifiable" and it is not possible to discern from these files what would constitute a notifiable incident**.
74. The Police did challenge the requirement of an earlier safeguarding protocol which was stringently applied. *It stated that unwanted physical contact or unwanted touch amounted to an assault. Belfast Trust refused to amend it, even though it resulted in the Hospital's postcode becoming the most violent place in Northern Ireland*. Good professional relationships were developed between the Hospital and the PSNI with the latter becoming familiar with the "the regulars" during Tuesday and Thursday clinics. With notable exceptions, a lot of the work was "a paper exercise." **Over a third of the files referred to the Police**:
75. With reference to Hospital practices, *incidents of weighted blanket and lack of observations in seclusion are not being progressed by the police// unmonitored* [in seclusion] *but door not locked so police do not believe this matter falls within any criminal remit// this incident meets the criterion for not reporting to PSNI// not a reasonable suspicion that a crime has been committed// incident does not meet the threshold for police intervention// even if X doesn't have capacity they will still take a statement// allegation has changed a number of times.*
76. The patients appeared to have been offered the option of police involvement, that is, *doesn't want police// has not requested the need for police involvement or any further investigation.*
77. On more familiar police territory, *police to interview staff…does not meet the threshold for PSNI involvement// police investigated an allegation* [of rape] *…she retracted*[21] *the allegation during the interview.* **Although there is some documented evidence of seeking to evaluate a patient's ability to testify and encourage truth-telling the extent to which the practice is routine cannot be ascertained from the files**.
78. **Some patients' families were instrumental in determining police involvement**, *patient's mother does not wish to make a complaint to PSNI on her behalf…not a reportable offence// family do not feel there are grounds to progress a police investigation.*
79. **The PSNI regarded the evidence of new staff and/or staff who were shadowing Hospital staff prior to patients' moving out as particularly compelling. They were new to a ward's custom and practice and spoke up**. **However, without exception they were ostracised and *had no support from management in the process.*** The absence of support is a signature of the isolation that is part of the territory of making allegations against colleagues. The personal costs are known to have been great even though the allegations may prevent the unchallenged continuity of previously unknown behaviour; give others strength to challenge; and it may yield self-respect and peace of mind.

[21] The circumstances resulting in either retractions and/or apologies are not documented in the files

80. Overall, **the files do not reveal how the Hospital dovetailed adult safeguarding procedures, inspections, professional regulation, police investigations, complaints, clinical governance and internal disciplinary processes**.

(c) Adult safeguarding protection plans

> *Staff informed inspectors that X had capacity to make the decision to inform his mother while his mother believed he did not…family excluded from protection planning process* (Six Mile 2012);
>
> *no clear protection plans were evident…staff unaware of where individual protection plans are stored* (Ennis 2013).

81. The Review Team was advised that MDTs "review the clinical aspects" of safeguarding events, contribute to the protection plans and provide managerial oversight.
82. There was no single document across all files which was labelled a Protection Plan. Discussions confirmed that increased staffing levels, "2:1" and variations on "enhanced monitoring" were the typical responses to safeguarding allegations.
83. It was stated in one file that *this is not a Protection Plan…but a decision of the ward manager for the protection of staff.* (Appendix 4 reflects on the workforce implications of this).

(d) Advocacy arrangements

> His *advocacy is provided by Mindwise who are resistive to coming on the ward…not in their contractual arrangements* (Six Mile 2012);
>
> *Inspectors concluded not sufficient practice presence of advocacy on ward* (Ennis 2012); *attendance at patient forums sporadic and advocate not present…inequity of access to advocacy for patients from Western Trust* (Cranfield 2012);
>
> *clear evidence that psychiatry and MDT had been advocating for discharge of a patient* (Cranfield 2013);
>
> *Advocates occasionally attend meetings on the ward but do not routinely visit or spend time with children being assessed and treated* (Iveagh 2012);[22]
>
> *physical environment not conducive to people's needs, particularly concerning noise levels* (Killead 2014);
>
> *advocates only available to see those subject to a care order* (Iveagh 2017);
>
> *Patient Forum meetings had begun* (Cranfield 2015).

84. The Review Team was advised that *Funding issues impact on the availability of advocacy. There is a carers' advocate to support families. However, advocacy is not well developed and*

[22] Although the children and young people's service is not within the remit of the Terms of reference its inspection reports are pertinent to this review since they reference identical themes to those of the Hospital: its purpose; advocacy; pressures re admission; staff numbers and skill mix; repeated RQIA recommendations; preventing admissions; the necessity of senior management oversight; the reduction of incidents; and young people's under-occupation

there aren't many hours available. It was inspiring to meet a member of the *Tell It Like It Is* [TILII] group state:

> *I tell people that it's not ok to be hurt…it's not ok if people say things. You've got to keep yourself safe – it's really important for when you go back to the community. I make sure to tell people that it's not ok to be hurt.*

85. It was noteworthy that **advocacy is typically absent from considerations of safeguarding**. Given the significance of this agenda and the fact that the Hospital is a high-risk setting, the Review team envisaged a much more proactive role for advocacy. For example, contact with people's families confirmed their anxiety about patients who do not have relatives advocating on their behalf. The RQIA reports, which comment on advocacy, would suggest that the practice of advocating on behalf of patients has been compromised by not meeting/spending time with patients.
86. Scrutiny of complaints made to the Hospital (see footnote 14) indicates that families have a lead role in advocating for their relatives. Complaints are less likely to originate from self-advocates and even less likely to originate from "advocates," Members of the Legislative Assembly, solicitors or the Northern Ireland Law Centre.
87. The Team was advised that the current advocacy input from Mencap and Bryson Care amounts to 25 and 30 hours a week respectively. Their reflections on the circumstances of Hospital patients are apposite:

> *People are caught here – it's not meant to be their home. It's what the staff can do. Patients come in at a low period – it grieves their families – and then they get stuck. It's sad because then they spend years of their lives in here. There aren't the places in the community and the Hospital is left now with the more challenging people…Staffing levels…there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards… We're involved with MDT meetings right from the start. There are concerns about staffing levels. It's the more able patients who can reflect on restrictive practices… It's difficult when they don't go out on trips and the staff get demoralised. When patients are in and out* (e.g. in Cranfield) *its unsettling for the long-term patients – some have been asked to give up their beds; some have been wrongly placed in the forensic unit and staff are not able to address this. I went to the top about the patient who had to give up a bed and spend the day on a different ward.*
>
> *Attrition levels in the community are sky high. Staff are paid minimum wages and they realise it's not worth the money. Patients return and it's generally due to untrained staff. Beds are kept for three months after discharge; they have to be readmitted for MH because staff in the community can't manage their behaviours, the situations escalate, and the police are called.*
>
> *The Hospital needs more staff and more 1:1 interventions for quality time; the patients need things to do, something worthwhile. We've been dealing with the smoking ban, raising this on behalf of the patients… The changes at the Hospital have been phenomenal in terms of how patients and advocacy is treated. We have access to the consultants.*

[Managers] *suggested that we went round the wards with them to see if we could see things that they are not seeing. Also, we've been asked to comment on two Hospital policies.*

88. It is axiomatic that public services should put centre-stage the experience of people who use them. An expanded version of advocacy is one that presents a fundamental challenge to services, that is, it brings to the foreground people's aspirations and it acknowledges the legitimacy of attempts by self-advocates and their families to positively influence the opportunities and services available. **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**. Such advocacy must connect outwards and upwards to arrangements for the provision of local services and outward and upwards again to the collective advocacy of the Trust.
89. **It is possible that the long association that advocacy services have had with the Hospital and the impact of protracted delayed discharges has blunted its core purpose**. The Review Team can see no alternative to advocacy activities which first and foremost promote and safeguard patients' Human Rights.

(e) Governance and Quality Assurance in learning disability services

Family *did not feel informed about his care…no documented record of the views in the meeting* (Six Mile 2012);

no specific explanation of monitoring role documented…the appropriate complement of staff for the ward remains unclear…will continue to monitor staffing levels closely, the recording of incidents, actions taken and adherence to clear governance protocols (Ennis 2012);

food quality poor…difficulties in accessing extra contractual referrals for specialist treatment (Cranfield 2012);

patient expressed frustration with the length of time it takes to be discharged (Cranfield 2013); *some relatives concerned about future care* (Greenan 2012);

*Little progress concerning privacy measures…people's experience could be perceived as degrading…disappointing…that patients were not experiencing care which would enhance their quality of life (*Moylena 2012);

one child's accommodation hinged on the leave arrangements of others (Iveagh 2012);

it should be a leading centre of excellence…was operating without the full range and availability of multi-disciplinary staff (Iveagh 2013);

care records were not formally audited (Erne 2014).

There's a journey to go to make sure that patients' voices are heard. "Your voice counts" has been crucial in listening to and learning from patients and their families – hearing first hand is better than any governance system. No system would have alerted us to what happened.

90. **The absence of *modern community-based services,* including home treatment, supported living and provider expertise, is unequivocally associated with crisis admissions and the sense of failure (i) for the patients, their relatives and staff and (ii) leadership in learning disability services – as one person noted, *we need more than politician's assertions*.**
91. One family described their bleak experience:

    When our brother was moved last year, it was on a "day trip" and a member of the Hospital staff went with him. She stayed overnight and the next day. He seemed happy and we emphasised that they could get in touch with us at any time – same with the hospital. But we slowly discovered that the staff were incapable of coping – they didn't listen to us about how they shouldn't put their heads down in front of him and yet they did – when we were there! He was there for five weeks and they never rang anyone for help. They had promised day care and swimming, but nothing was done. They gave him board games on the dining room table. Being at the table to him means having food. He attacked a member of staff and we were told on a Monday that a decision would be made by Wednesday. They must have decided that afternoon that he was going back to the Hospital because he went on the same day. With all the movement of staff at the Hospital he was with new staff he didn't know, and he became so bad we didn't think it could get better. At the placement he was stir crazy because they didn't know how to work with him and nothing was in place for him. He lay on the sofa for five weeks. It was a bungalow for six people, but one person stayed in his room for the whole of the time. He had been assessed by the people from the bungalow but the one time we visited we were told "he's wrecking our house!" Why are they not answerable? Why are they still registered to care for people with learning disability, challenging behaviour and autism?

    [The service] *talked about Person Centred Plans for everyone. We asked if they would cope if he developed dementia and they agreed that they would. Yet they couldn't be bothered to work with us as a family. Northern Trust had sent an extra member of staff to help. One day I arrived and there was no chat – the place was in chaos. The nurse was on the phone to the doctor and residents were locked in their rooms for safety. She was panicking…We want him to go out again but this time – with some honest engagement.*
92. Research[23] has identified **five components of effective governance**:
    i. **clarity of goals**, scope of activity and purposes, including shared principles, multi-agency commitment and strategic leadership
    ii. **structures**, including clear divisions of responsibility and mechanisms for communication, and explicit linking between functions or activity
    iii. **membership**, including a clear rationale for inclusion of agencies, understanding of roles, responsibilities and commitments, evidence of engagement and protocols for chairing, quoracy, resource contributions and business management

[23] Braye, S., Orr, D. and Preston-Shoot, M. (2012) The governance of adult safeguarding: the findings from research *The Journal of Adult Protection* 14 (2), 55-72

iv. **functions**, including strategic planning and operational oversight, appreciation of the difference between governance and executive management, and a strong developmental and improvement agenda which embraces audit, performance management and quality assurance

v. **accountability**, including standards for and assessment of committee performance, clarity about decision-making authority and reporting channels and explicit links to other partnerships.

93. **Thus, governance requires more than place hunting to move people out of the Hospital**. It is about recognising the aspirations of so many families for ordinary lives with individualised support; stimulating and shaping the contributions of all agencies to set out a vision of the opportunities and support which should be available to people with learning disabilities and their families over the life course. Irrespective of Bamford and the very considerable efforts to reduce the Hospital's population, **it appears likely that most families have seen little change.**

94. This Review confirms the significance of:
    - focusing on people's lives and those of their families and embracing a partnership model in which all are active participants
    - designing supports which enhance people's sense of achievement, belonging, continuity, purpose, security and significance
    - having clarity of purpose with clear criteria for Hospital admission, that is, no re-admissions arising from "breakdowns" for example; commissioner led "care and treatment reviews" concerning potential admissions
    - training for service development for all staff to facilitate the transition from segregated provision to mainstream opportunities. At the Hospital this will involve Continuing Professional Development, clinical supervision, and support for ward staff for example. In the community, this will involve "out of hours" support, enhanced roles for community teams, risk registers identifying people whose support is becoming fragile
    - redefining agency responsibilities and moving away from "specialist" to mainstream services, that is, commissioning for in-patient *and* community services.

(f) The implementation of recommendations arising from safeguarding investigations and RQIA inspections[24]

Recommendations during inspection of 2010 were assessed, some were restated (Greenan 2012);

Concerns highlighted in previous inspection had not been fully addressed (Moylena 2012);

several recommendations remained outstanding from the previous inspection (Iveagh 2012);

there were a total of 34 recommendations made following the last inspection (Cranfield 2015).

[24] See Appendix 6

95. The Review Team understands that the RQIA has an inspection process for individual wards. There was no evidence of an overarching view of the Hospital. **A hospital is more than the sum of its wards. Patients have left, wards have closed, and the Hospital has demonstrated its resilience. The Hospital's interconnections are less visible, for example, the criteria for admission and discharge, the budgets, the gossip and the functions and purpose**. The 61 RQIA inspection reports concerning Hospital wards were found to contain a lot of recommendations – the initial five which were skimmed contained 18, 26, 23, 6 and 44 recommendations. The Review Team noted that two reports stated: *concerns highlighted in previous inspection had not been fully addressed…several recommendations remained outstanding from the previous inspection.* Three other 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.* Such observations have consequences for the ways in which inspectors organise their work, manage their discretion and report on performance. The principal topics on which the Review Team focused were:
    - patient experience
    - safeguarding practice and
    - recording at the Hospital.
96. These topics are evidenced in the RQIA reports, to which were added the additional themes of:
    - institutional practices
    - the workforce
    - multi-disciplinary working
    - the purpose of the Hospital
    - restrictive practices.
97. A Briefing Paper (see Appendix 5) outlining these themes was circulated to the commissioning managers (Appendix 6 is the response of the RQIA to the Review Team's paper). The documented observations of inspectors are reflected in the Review Team's findings.
98. An RQIA overview report of February 2013 noted,

    …the identification of safeguarding issues includes the concerns and complaints received from patients, relatives and staff. Information of this nature can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation's complaints procedure (p.19).[25]
99. **The interface between complaints and safeguarding is unclear**.

[25] RQIA (2014) *Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland – Overview Report*

(g) Leadership

Seeking alternative solutions to admission…more robust home treatment or crisis response solutions…to prevent children…being admitted on a crisis and emergency basis (Iveagh 2012);

unclear about the role of the unit (Oldstone, 2013);

urged to give urgent priority to establishing a more robust, tiered model of intervention in the community to ensure Iveagh beds are used appropriately…need to consider a step up/ down unit to enable young people to receive alternative supports…some misunderstanding/ differences concerning the purpose of the centre was evident (RQIA, Iveagh 2013);

police attended and used leg restraints and handcuffs (Iveagh 2014);

staff…highlighted that continued support and oversight…from senior management team

would be key to continued improvement within the service (Iveagh 2014);

lack of managerial and clinical input (Donegore 2016);

re allegation of *unsafe staffing level…substantiated, however, levels had improved due to a reduction in staff absence and re-deployment* (Cranfield 2017).

100. The Review Team accepts that leadership is distributed across individuals, including those who have experience of safeguarding and their relatives. The Team was advised that the Hospital has recently endorsed *collective leadership* and that although, *the psychiatrists are supposed to provide clinical leadership…historically it's not happened.*
101. **The circumstances of patients with learning disabilities require a network of leaders inside and outside the Hospital. Managers who are working independently of each other, seeking to address problems that interact with the problems of other managers, need more than the promise of the full implementation of the Bamford Review** – now 14 years old.
102. **Any coalition for progress must begin with individual experiences**. These must exercise tangible influence over decisions about setting priorities, sharing leadership, exploring new planning and delivery arrangements, using resources, working with and through other agencies, learning from cycles of diagnosis, development and review, and demonstrating that the impact of all decisions on people with learning disabilities is intrinsic to identifying the skills, people, organisation and systems changes required.

(h) Good practice

103. The Hospital has made real progress in relocating hundreds of patients since the 1980s and 1990s. The Hospital and community services have demonstrated that they are well placed to contribute to the next larger scale cycle of change.
104. There is a strong sense of the importance of being proactive. *Strategically we need to work with these families* [when the children are at] *pre-school – not the point at which their families are burned out e.g. 24 LD nurses have trained as health visitors and the feedback from families*

is really positive. This observation is as compelling as the evidence which supports it. **Families with infants with learning disabilities and other developmental challenges vary as much as all families. However, over time some families experience difficulties and restrictions in activities and relationships, most particularly where high levels of behaviour challenges emerge. The most valued services meet children's and families' needs and are positive about the immediate future. They involve parents and they liaise with all other services. No families with relatives at the Hospital described such attentive early intervention**.

105. One staff team has provided necessary support to a patient who alleged being harmed during a visit home and who becomes distressed at the prospect of subsequent visits.
106. Killead explicitly recognises the importance of engaging in interesting and enjoyable activities. This women's admission ward draws attention to the pleasures of being able to choose what to do. They are assisted by staff who understand the importance of providing the kinds of opportunities and routines which are valued by all of us.
107. The initiative of a ward manager to document an approach characterised by conflict resolution merits particular attention. It could have invoked a safeguarding investigation, yet the approach adopted acknowledged and documented the felt and expressed harm. The relations of power at the Hospital are complex and subtle. The ward manager sought to explore a solution which changed the relationships of the two men concerned. The Review Team commends this approach because the resolution of conflict hinges on the art of facilitating an appropriate process for those in dispute to problem-solve together and, through the process, to reconstruct their relationship.

(i) Other relevant matters

108. With reference to patients' **health status**:

> *patients had been unsettled…many with UTI…had condition which caused regular bleeding* (Ennis 2012);
>
> *screening patients for physical healthcare needs was an issue* (Cranfield, 2014);
> *an overarching clinical summary of each patient's psychological and medical condition was not available* (Erne 2014);
> re *people's access to physical healthcare screening…no progress* (Cranfield 2016).
>
> Inquest of Hospital patient, November 2014: *death due to choking on food.*
>
> Inquest of Hospital patient, October 2017 who died in 2015: *due to a history of swallowing difficulties X was considered to be at risk of aspiration…a member of staff was in arm's reach when X was in the dining room…a post mortem examination…revealed the presence of a metal teaspoon in the small intestines.*
>
> *We have rubbish data – nothing useful to enable projections or effective decisions.*

109. The Review was advised of a lack of general medical services at the Hospital *We need GPs alongside the MDT.* **People with learning disabilities are disadvantaged in terms of their**

health status compared with the general population - they have greater mortality, more significant health conditions, and they experience poor standards of health care. It is this inequality which justifies a focus on research evidence concerning what is known about the special care and attention owed to infants and children who have extensive medical and health support needs and for whom the quality of their lives is an immediate and urgent challenge (see Appendix 7). It is critically important that all services demonstrate their readiness to plan for the treatment and care of these emergent generations and monitor on a continuing basis how they and their families are faring.

110. **Opportunities to engage in interesting and enjoyable activities**:

> *weekends long with few activities* (Cranfield 2012;
>
> *some patients only getting up at 11.30…outings off ward limited* (Greenan 2012);
>
> *evidence of some people experiencing restrictions due to the needs of their peers…patients spending majority of time in group rooms…no choice…no evidence of the provision of activities* (Moylena 2012);
>
> *no ward-based schedule for therapeutic activities* (Cranfield 2013);
>
> *would like more activities to take part in, especially in the evenings* (Iveagh 2016);
>
> *there are not a lot of activities at nights* (Cranfield 2017);
>
> *people who do not attend day care complain of boredom* (Cranfield 2015).

116. The Review Team was informed that inactivity within the Hospital remains to be addressed because *Patients are bored! There is a lack of stimulation and that's part of the picture. There's a lot of sitting about with no staff interaction; there is a lack of line managers on* the *wards.* Patients' inactivity has safeguarding implications: *there was seven-day a week day service – the majority of safeguarding incidents happen at w/ends/ Out of Hours when there are more patients about* with nothing to do.

117. **CCTV** – a patient noted that, *With the issue in the hospital we don't know about it. We were happy we were safe so now it's a good thing that they have cameras that they're being watched so the patients can know it is safe. The cameras are good.* However, some staff suggested that, *there's a fear among staff and they leave. They're rushed and they're fearful that they might lose their PIN. Yes, we wanted the CCTV, but we're worried about how we can be perceived. Staff are fearful – it's palpable. The job is changing because of the CCTV and the investigations.*

CONCLUSIONS

> *I say to patients, "You will get better – but not in this environment!" The single most effective therapeutic act of an Assessment and Treatment service is to discharge patients. It results in a majority of behaviours disappearing. The tasks of Assessment and Treatment do not require repeating and should occupy no more than six months, after which I explain, "This is it. This is as good as X is going to be. If X is not discharged she will deteriorate"* Dr Ashok Roy.
>
> *"Being here has helped me a lot but I'm fed up waiting on a place in the community"* (Cranfield 2017).
>
> *We need a change of culture from a residential campus to a hospital ethos.*
>
> *On women's admission we have a lot of readmissions. The women feel safe and secure here and a lot of the readmissions would be social e.g. the breakdown of a relationship. They maybe short – a day or two. Then there are those who don't feel they can go back to the community.*

118. **The Hospital's compromised progress in resettling long stay patients and in addressing the acute need arising from mental health delayed discharges impact on safeguarding and are compromising the capacity of the Hospital to provide Assessment and Treatment. Safeguarding must be seen in this context and against this backdrop**.
119. **The Hospital should only be used for rapid and short-term admissions since such admissions result in better outcomes. An Assessment and Treatment service is not a respite service. Historical reliance on the Hospital by some Trusts means that it is the self-perpetuating default placement for ex-Hospital placements, irrespective of their prior Assessment and Treatment**. The Hospital, its commissioners and community services have learned that when former patients are not offered support to sustain important relationships, to have better physical and mental health, and fuller, richer lives, their behaviour deteriorates, and they become homeless.
120. The families of current and former patients are alarmed at (i) the failure to honour the promise of *betterment* for former Hospital patients, most particularly in relation to those without families to advocate on their behalf, and (ii) the power of current community services to exclude former Hospital patients, abdicate responsibility for the impacts of their decision and return them to the Hospital.
121. **It is possible that repeated exposure to chronic and low-level allegations, to outbursts of distressed behaviour, and to violence directed at peers and staff are perceived as "normal" at the Hospital. It is possible also that a superseded policy requiring the involvement of the PSNI has skewed understanding of what proportionate responses to allegations arising from the Hospital should look like. However, since the copious paperwork associated with investigations and inspections did not uncover the abuses captured on CCTV, development beyond the procedural rigidity of the safeguarding and inspection processes is warranted**.
122. **New Hospital staff and visiting staff who were unfettered by loyalty to the Hospital employees had high expectations of their colleagues' behaviours and were perceived by the**

police to be valuable witnesses. Although their allegations had the potential to begin to shape a different kind of work culture, it could neither stop individuals against whom allegations were made from taking long term sick leave and/or resigning nor could these newly vulnerable staff insist on the support of senior management. The safeguarding and PSNI task were most challenging when there was no evidence other than the testimony of a patient and the denial of the accused.

123. The test of policies and practice is the improvement they bring to people's lives. The Review Team takes the view that since there is no evidence that seclusion works, it is best avoided. Although the behaviour which triggers use of the seclusion room will stop, this is more likely to be due to a patient's physical exhaustion than evidence of a promising therapeutic benefit. The practice is experienced by some patients as punishment. Such routinised practice represents "containment within containment." It has not required high level authorisation. The CCTV coverage does not suggest that seclusion is the response of last resort at the Hospital.
124. Appendix 3 highlights the variation in responses to allegations in which the typical "constant" or "Protection Plan" is to increase staffing levels. This is remote from the underpinning principles of safeguarding. The methods of reconciliation explored by a single ward manager set out a basis of firm progress for the settlement of particular disputes, that is, between formal safeguarding procedures and pragmatic diplomacy, where there are untried possibilities. This is an opportunity for learning across the Trusts. The Review Team believes that a more judicious use of the safeguarding procedure is required.
125. **Just as the Hospital's decline was associated with becoming rundown, understaffed, overpopulated and obsolete as a model of service provision during the 1980s and 1990s, in 2018, it is based on an acute care model that does not work for people with life-long support needs**. There is proven mileage designing pathways of care with families whose relatives are at different stages of the life course, including those with life-limiting conditions. This may include Assessment and Treatment services but not necessarily in an in-patient setting. It should not be serially available to the same patients. It is a specialised supplementary service which should be provided only to the extent that it is required. It should not exercise control over all or most aspects of a person's life.
126. How staff work with the people they serve is critical to efforts to create individualised services. Commissioners, clinicians, social care staff, community teams, Personal Assistants and families will want to see examples of valued outcomes arising from securing tenancies for people for whom the Hospital may once have been regarded as the only option.
127. Real gains will be made when the Department of Health and all Trusts draw and disseminate lessons from people who are experienced in planning and securing supports around individuals:
    - The goals of coalitions of parent groups throughout the life course, including those with experience of accessing Direct Payments
    - General practitioners, Practice Nurses and paediatricians and geriatricians responsible for coordinating the health care of their patients with learning disabilities

- Community Teams attuned to the families which are known to require a great deal of assistance and/or may be considering sharing or relinquishing care
- Mainstream schools, colleges, supported employment and leisure centres
- Faith communities with experience of involving people with learning disabilities as full members
- Adult fostering and shared care
- Ordinary housing schemes for people with learning disabilities
- Imaginative transition planning in which people's IQs are of no consequence.[26]

[26] The Review Team was advised that people's IQ determines their eligibility for adult services

LEARNING IDENTIFIED
Accessing a safeguarding response should not require negotiating obstacle strewn territory. Considerations of whether a patient (i) "has a history of making allegations" (ii) has mental capacity (iii) has the permission of their family and/or (iv) meets thresholds, may preclude support to the patient to understand processes associated with safeguarding and/or a police investigation for example. Whether or not safeguarding processes are invoked cannot be determined solely by people's relatives or psychiatrists. It is not feasible for psychiatrists to establish whether all citizens with learning disabilities and autism in Northern Ireland have capacity to benefit from, *inter alia,* the scrutiny of adult safeguarding activities or even participation in safeguarding training.
The responses of staff to allegations of harm and/or to witnessing harm are situational. It is stressful witnessing violence when (i) personal safety may be threatened and (ii) some kind of help is required. The support of senior management must be explicit in the reporting process, that is, the consequences of reporting, the rights and protections which may be expected should be set out. The best reporting procedures are voluntary, non-punitive and protected.
There's a journey to go to make sure that patients' voices are heard…hearing first hand is better than any governance system. Meeting with the families of Hospital patients whose communication is limited and who were observed to have been harmed is more illuminating than the patients' records and accounts of investigations.
Muckamore Abbey Hospital must be mean, lean and purposeful. Get the overall vision right and make changes. It mustn't be seen as offering all sorts – it should provide short term A&T. That's the vision of the new co-director. This is a horrendous environment to live in – that knowledge has to pervade the whole system. A&T has to be slick – a place where people are happy and safe - and less than half the current size. Diversion from the courts doesn't mean that people are here permanently so that families get used to it. People don't have to live here – in the middle of the country – to go out for a walk. The Hospital is nested within the Belfast Trust, within the sum of Trusts, within the Department of Health, and within the Legislative Assembly. It follows that changing one element of these has the least effect on the whole system. The whole system will carry on being itself, changing only slowly if at all. A system's elements, interconnections and purposes are all critical – and the case for major change is incontrovertible.
The *life course* perspective of families of people with learning disabilities is relevant to the aspirations of families and to safeguarding practice. Patients' biographies involve their families and communities, continuities and discontinuities across different environments – including settings where there is a premium on privacy and trust. Such perspective shifts the focus to understanding the life stage of the patient, what is known about their history – including the experience of abuse or harm earlier in their lives - as well as the Hospital and ward context. What outcomes for patients can the Hospital report? It does not appear that the Hospital keeps track of the lives of former patients unless they return. This compromises the Hospital's credibility in setting out its achievements with and on behalf of patients. It is highly *unlikely* that the families of infants with learning disabilities and complex neuro developmental disabilities envisage Muckamore Abbey Hospital as part of their waiting future.

RECOMMENDATIONS

The Review Team recommends that there must be:

1. 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 – which will change over the life course.

2. 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. 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 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.

POSTSCRIPT

Points and recommendations proposed at the feedback sessions of 24 & 25 September 2018

Patients' relatives supplemented and underlined the bleak accounts of the experiences set out in the review. For example:

There's a lack of communication…there's no information sharing…we weren't allowed to read his file…why is information not shared?

We couldn't have him at home. We were told if we took him for a night, he would lose his place on the ladder. We waited for a year and after a year we were told he didn't have a place

She used to talk about going to the bungalow for a year. Then there was nothing. She no longer talks about the bungalow

For a long time, I raised issues and I wasn't listened to. I don't feel I was listened to…X was assaulted five or six times. I made complaints of course and nothing happened. When I reported what my relative was saying I was told that X was wrong

There is no need for a seclusion room. My X was put in it. It's not treatment putting someone in a room they can't get out of. They didn't listen when I challenged it

There's a lack of normality for our relatives. Patients are moved around the hospital site. They are distressed, and they hurt each other

This should be a homely place - like it used to be

It's nothing like a home. It's even worse than prison

They leave Iveagh at 18 and then they come here!

They're not getting out enough…it's cabin fever…why not open up a couple of wards?

It's obvious that you can't put distressed people together

I want to see the end of seclusion. Why does it exist? It is anything but therapeutic

The doctors, the managers – they all knew what it was like

What about the staff who are not registered? What about the staff who are responsible for the harm?

I have lots of questions about what happened to X. Will they be answered?

What was the RQIA doing? What was the Trust doing? What's the point of all this form filling if people are getting hurt?

Bad management has a knock-on effect

The staff should be moving around the hospital site

You don't need to apologise – it's the former managers who should be apologising. Those managers were ruthless and closed everything down. They are the ones who should be made accountable

The culture changed a few years ago when there was nowhere for patients to move to. I have to hope that my X is happy here. This hurts me. I want good support for people here – ways to fill their days that don't hurt them

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 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 the Hospital may undertake with (i) voluntary patients and (ii) sectioned patients[27]
- 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

The feedback was uncomfortable for **Hospital Staff** to hear:

- *You're talking about harms when they are allegations*
- *What incentives are there for staff to remain here?*
- *Partnerships are very challenging and these need to be more robust most particularly if we are to see appropriate and timely discharges*
- *In Northern Ireland we have to start working with children at an early age – we're very reactive in Northern Ireland. We have to be more focused. Muckamore Abbey is the biggest unit in NI and we should have the skills here. We should be reporting on research. We should be planning forward*
- *We're at a tipping point. The resettlement agenda has been lost*
- *There are some encouraging things – learning disability nurses/health visitors*
- *There are so many small things that would make a positive difference e.g. having a second bus*
- *There are too many walls between the Trusts and the Hospital*
- *We want to intervene early and support people in their decision-making*

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

- *The pressures are constant. I have never seen any abuse in all the time I have been here*
- *The lack of focus affects all our work*
- *The activities have all been stripped away*
- *Families are in crisis for a long time and have no support*
- *Safeguarding processes are slow, and the paperwork is crazy. We have people coming here from England and Wales and they can't believe that we have to report everything and spend hours filling in forms*
- *What about staff safety? I was head-butted in the face yesterday*
- *Staff morale is terrible*

Staff recommended that:

- An enhanced role for specialist nursing staff is set out
- 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 reported that there was "no dissension" about the urgency of patients' circumstances.

- *There's a lack of robustness of community services…the energy has gone from community development…it affects other care groups too…Supporting People isn't delivering, and the processes aren't doing what they're supposed to be doing…There is underfunding*
- *It'll take time to develop the transformation required…this is for the system*
- *We could begin collectively commissioning*
- *We're all in this together…there is more to do*
- *The CNO is aware – the skills of MAH nurses are transferable*
- *We need to go forward in a tiered way…there is urgency because we can't be confident that MAH is safe…there is vicarious guilt*
- *What if a nurse states "I cannot run this ward safely"?*
- *We should be bringing leadership and values to the Learning Disability population…it's a shared responsibility…begin with small steps - in the community*
- *We know that there are perverse incentives…we have to push back to the Trusts which are seeking to admit patients to MAH…there is pressure to admit people who require behaviour crisis management.*
- *"There are no alternatives// there aren't the community placements"*
- *We could state "We'll receive no admissions after 5.00 on Fridays and at weekends."*
- *We might build up an evidence base of prospective data*
- *There's a DH workshop in November which stems from Bamford. It's setting out a five-year plan*
- *We can get lots done now…It's up to us to deploy leadership and bring energy to the task…Trusts and community services have over-relied on MAH*

- *Our language matters and we should use it carefully…we're placing expertise in the community – staff are key to doing a good job.*
- *there has to be a shared narrative…we can't carry on doing what we've always done*
- *There has to be a new beginning – an acknowledgement that people have suffered harm…there have been totally unacceptable events – there is a collective sense of shame and embarrassment…we have to start working outwards – working with the independent sector*

Senior Managers recommended that:

- A shared narrative is set out
- Commissioners specify what "collective commissioning" means
- The transformation required in learning disability services must be values driven and well led
- The purpose of all 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[28]
- 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[29]

[28] At the time of the feedback events, the Hospital was addressing its low threshold for admissions

[29] 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 demand

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RO14 [redacted]

Appendix 1

How the *Senses Framework* may stimulate change at Muckamore Abbey Hospital

Background

1. To promote better lives for people with learning disabilities it is recognised that it is important to develop new opportunities as well as change the ways that public authorities go about their work. However, there is a danger that the pressures for change and reform become "ends" in themselves.

The environment

2. The ward environments impact on patients, their families and staff. Experience of the re-provision of services to less segregated settings does not necessarily herald improved lives for people with learning disabilities. If poorly resourced and managed, depersonalising environments and regimented care practices may also be found in smaller settings.
3. The Review Team has highlighted the quantity of assessment tools identified by the RQIA which are used at Muckamore Abbey Hospital. These include, for example, Person-Centred Care Plans, Personal Activity Plan, Care Plans for Each Need Assessed, Positive Behavioural Support Plans, Individualised Incentive Plans, Patient Progress Records, Progress Notes, Assessment of Communicative Needs, Functional Analysis of Care Environments, Risk Assessment and Quality of Life Assessments (see Appendix 5). The Team's contact with patients, staff and relatives underlines the importance of creating and nurturing 'healing' environments. The *Senses Framework* offers a credible means of creating an environment in which the needs of patients, their relatives and staff are acknowledged and addressed.

The *Senses Framework*

4. Nolan, Davies and Grant (2001) sought to link theories, conceptualisations and research evidence. The *Senses Framework* is derived from, and reinforced by, an extensive literature search and 'testing' in acute settings as well as long term environments. By 2012, the 'senses' had been further developed "by, with and for older people, family carers, staff and students..." (p105).
5. There are six 'senses' each of which is pertinent to all of us:

Sense of achievement

For people with learning disabilities:[1] opportunities to meet meaningful and valued goals; to feel satisfied with your efforts; to make a recognised and valued contribution; to make progress towards therapeutic goals as appropriate

[1] In M. Nolan and S. Allan (2012) the table references *older people*

For family carers: to feel that you have provided the best possible care, to know you have 'done your best;' to meet challenges successfully; to develop new skills and abilities

For staff: to be able to provide good care; to feel satisfied with your efforts; to contribute towards valued therapeutic goals; to use your skills and abilities to the full

Sense of belonging

For people with learning disabilities: opportunities to maintain and/or form meaningful and reciprocal relationships, to feel part of a community or group as desired

For family carers: to be able to maintain/improve valued relationships, to be able to confide in people you trust; and to feel that you are not in this alone

For staff: to feel part of a team with a recognised and valuable contribution to make, to belong to a peer group, a community of practitioners

Sense of continuity

For people with learning disabilities: recognition and value of personal biography; skilful use of knowledge of the past to help understand the present and future; seamless and consistent care delivered within an established relationship by known people

For family carers: to maintain shared pleasures/pursuits with the person; to be confident that the person receives high standards of care whether delivered by self or others; to ensure that personal standards of care are maintained by others; to maintain involvement in care across care environments as desired/ appropriate

For staff: positive experiences of work with service users from early career, exposure to good role models and environments of care, standards of care communicated consistently and clearly

Sense of purpose

For people with learning disabilities: opportunities to engage in interesting and enjoyable activities; to be able to identify and pursue personally valued goals and challenges; to exercise choice

For family carers: to maintain the dignity and integrity, well-being and 'personhood' of the person…without ignoring other valued goals

For staff: to have a sense of therapeutic direction, a clear set of goals to aspire to

Sense of security

For people with learning disabilities: attention to essential physiological and psychological needs, to feel safe and free from harm, threat, pain and discomfort; to receive competent and sensitive care

For family carers: to feel confident in their knowledge and ability to provide good care without detriment of personal wellbeing; to have adequate support networks and timely help when required; to be able to give up caring when appropriate

Paid caregivers: to feel free from physical threat, rebuke or censure; to have secure conditions of employment; to have the emotional demands of work recognised and to work within a supportive but challenging culture

Sense of significance

For people with learning disabilities: to feel recognised and valued as a person of worth, that your actions and existence are of importance, and that you 'matter'

For family carers: to feel that your caring efforts are valued and appreciated and to have an enhanced sense of self

For staff: to feel that your practice is valued and appreciated, that your work and efforts 'matter'

6. A human rights perspective is the central theme grounding adult safeguarding in Northern Ireland. It is especially pertinent to the men and women at the Hospital since they are dependent on health, social care and accommodation where practices such as partnership working, and assessment are critical. The Senses Framework draws attention to the day to day experience of people's lives as well as the reciprocity involved in all aspects of care.

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Appendix 2

A Historical Context to the Review

Background

Ian Montgomery and Joe Armstrong (2009) wrote, *From Specialist Care to Specialist Treatment: A History of Muckamore Abbey,* which was published in Belfast by the Ulster Historical Foundation. It sets out the principal milestones and themes in the hospital's history. In addition, the Northern Ireland Assembly's Research and Information blog[1] is referenced. This details relevant reviews, policies and reports.

The Timeline

During **1946**, the Gordon Report on mental deficiency in Northern Ireland was published.

During **1948**, the Mental Health Act (Northern Ireland) made the Northern Ireland Hospitals Authority responsible for '*persons requiring special care*.'

During **1949**, the Muckamore Abbey estate was purchased for a new hospital. Initially, the house had accommodated four "*high grade*" girls.

During **1951**, the Special Care Service Management Committee was established.

During **1952**, an extension was built at Muckamore Abbey, increasing accommodation capacity to 68 beds. It had 51 patients. It was noted that it was "*not easy to separate older girls from younger groups who have not yet developed anti-social tendencies.*" Also, efforts were made "*to avoid chaotic conditions arising from…the indigestible mixture of patients of all grades.*" There were 743 patients accommodated in six mental hospitals in Northern Ireland, 120 of whom were children. The opening of Muckamore Abbey Hospital meant that all young people and adults over 16 years were finally removed from mental hospitals.

The purpose of provision for children, young people and adults with learning disabilities over the course of the hospital's history included: helping with socialisation; training; occupation and recreation; to return to the community; supervised employment (for a minority); accommodation for those with *poor moral sense/*whose families were unable to cope/unable to fend for themselves; to make a worthwhile contribution to the costs of administration – including growing vegetables and assisting with cleaning, mending clothes and maintenance work, for example. Also, farming was perceived as a therapeutic activity. Additional purposes for Muckamore Abbey included being a halfway house and a centre for medical research. Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patients living there long term. However, due to problems in discharging treated patients, "*serious overcrowding*" has resulted.

[1] http://www.assemblyresearchmatters.org/2017/03/08/mental-health-illness-northern-ireland-1-overview-related-strategy-reports/ (accessed on 17 March 2018)

Also, during 1952, the Association of Parents of Handicapped Children was established. *Later when Muckamore Abbey Hospital opened, the Association became known as the "Society of Parents and Friends of Muckamore Abbey Hospital".*[2]

During **1953**, a £2m special care colony was inaugurated. Also, a company of girl guides was formed at the hospital.

During **1955**, nurse training began at Muckamore Abbey Hospital. It was noted that "*this type of nursing, which is more of an instructional or training nature, often appeals to the girl who is not attracted to the routine of nursing in general hospitals.*"

The numbers of people diagnosed as requiring hospital care grew.

By **1958**, it was noted that at Muckamore Abbey, "*TV viewing has become a very popular evening pastime*."

During **1960**, the school opened and "*in some cases pupils learned to read and write.*" There were nine villas on the site. These were designed to accommodate ambulant patients and were unsuitable for those with additional physical support needs.

During **1961**, a school was opened at Muckamore Abbey.

During **1966**, Muckamore Abbey had 880 patients.

During **1967**, the swimming pool opened.[3]

During the **1960s**, hospital staff were less willing to live on site. One villa accommodated 40 men, some of whom were doubly incontinent/removed clothing/pulled down curtains/broke windows and self-harmed, for example.

During **1963**, a teacher's college opened at Muckamore Abbey for special needs teacher training.

During **1964**, Muckamore Abbey had its own cinema and radio.

During **1965**, most of the hospital's land was transferred. Farming ceased as a therapeutic activity since the hospital no longer had large numbers of physically fit patients.

During **1968**, 200 rugs were made by patients; the hospital laundry dealt with between 55k-65k items each week; and the stationery used by the ESCS was printed at Muckamore Abbey.

[2] From the Society's leaflet, *Caring in Partnership*

[3] The Society of Parents and Friends of Muckamore Abbey Hospital *raised hundreds of thousands of pounds to improve patient facilities including major contributions to the hospital swimming pool…Community Centre building funds…also donated numerous items of equipment e.g. the bicycle scheme* [Caring in Partnership]

During **1969**, the Inquiry at Ely Hospital, Cardiff identified, *inter alia,* the combination of poor buildings, inadequate funding and a shortage of trained staff. This was subsequently referenced by managers and clinicians seeking additional funding for Muckamore Abbey.

By the late **1960s** and early **1970s** there was a growing sense that treatment and training should take place in the community. Overcrowding at the hospital was becoming a problem.

By **1970**, 344 of the hospital's 814 patients were assisting with the hospital's routines.

During **1971**, the sports pavilion opened at the hospital.

During **1973**, because of Health Service reorganisation, the Eastern Health and Social Services Board became responsible for Muckamore Abbey. The latter provided accommodation and the District Social Services teams became responsible for day care.

During **1978** the DHSS published *Policy and Objectives: services for the mentally handicapped in Northern Ireland.*

By **1980**, there were more than 20 villas on the hospital site. The hospitals workshops integrated men and women patients. A survey determined a decrease in the number of patients deemed suitable to transfer to the community.

During **1984**, the number of children and young people resident in hospitals was declining, that is, 81 out of 1,428 (Independent Development Council, 1984). However, Muckamore Abbey was one of the largest hospitals in the UK. Nearly 50% of its patients had no "off ward" activities.

A rehabilitation unit was created during **1986**.

During **1987**, special schools transferred to Education. At Muckamore Abbey, a unit for patients with profound handicaps was created.

Individual care plans were introduced during the late **1980s**.

During **1990**, a snoezelen room was opened at Muckamore Abbey.

During **1992**, nurse training ceased at Muckamore Abbey. *Health and Wellbeing into the new Millennium* determined that each Board and Trust should develop a comprehensive range of support services by 2002; that long-term institutional care should not be provided in traditional specialist hospital environments; and that the number of adults admitted to specialist hospitals should reduce.

By **1993**, the fabric of the hospitals buildings required attention and the hospital received a cash injection. The dispersed colony layout resulted in the underground mains becoming overloaded; there were heating problems; and asbestos was present in the buildings. There

were 596 patients at the hospital. Muckamore Abbey argued for the retention of a specialist Assessment and Treatment function on site, boosted by a petition with 7k signatures.

A forensic unit was established during **1994.**

By the mid-**1990s**, the presence of adolescents on adult wards had become a "significant issue."

During **1998**, Pauline Morris' study of long stay hospitals was published. This criticised the clinical model of care and commended a socio-therapeutic model in which training was as important as nursing and medical functions.

It was acknowledged that in the absence of a community infrastructure in Northern Ireland to support long stay hospital patients, those who had been in hospital for 30-40 years should remain there. The resettlement of patients was primarily driven by the availability of private and voluntary facilities. The average yearly cost of a single patient was £25k. The resettlement of 50 patients would result in a net loss of income of £1.25m.

During **2001**, the closure of seven wards was approved. These were inappropriate living environments.

A survey determined that most admissions to Muckamore Abbey were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.

During **2002**, the Department of Health, Social Services and Public Safety initiated the Bamford Review of the law, policy and services affecting people with a mental illness or a learning disability.

The Review's key messages included – the promotion of positive mental health; a need for reform of mental health legislation (Mental Capacity Act (NI) 2016); a shift from hospital to community-based services; and the need to develop specialist services, including for children and young people.

There have been two Bamford Action Plans, 2009-11 and 2012-15.

An evaluation of the Action Plan 2009-11 listed the challenges identified in 2009, including:

- *Streamlining access and establishing a stepped care approach;*
- *Enhancing the range of options available to primary care professionals;*
- *Improving access to psychological therapies;*
- *Home-based care and support to be the norm;*
- *A systematic approach to focus on 'recovery' from long term conditions; and*
- *Increasing the range of specialist mental health services.*

The 2012-2015 Action Plan contained 76 actions. The interim monitoring report noted that good progress had been made with 63 actions on target. In 2016, the Department of Health (NI) initiated a full evaluation of the 2012-2015 Action Plan – publication is expected by the summer of 2017. It will assess how Departments have performed, include the views of service users and carers, and identify needs and service gaps.

Initial findings include a continuing need to – promote psychological therapies and the 'recovery' concept; provide more practical support to carers; improve access to mental health crisis services; improve patient experience in acute facilities; increase involvement of the voluntary/community sector; and increase (supported) employment opportunities/social enterprises.

During **2003**, the business case for a new Core Hospital was made. The refurbished swimming pool re-opened.

During **2004**, *Equal Lives* was published. This envisaged no patients living in hospital and people with learning disabilities living in residential services and their own homes with support.

During **2005**, a regional strategy was published, *A Healthier Future: A twenty-year vision for Health and Wellbeing in Northern Ireland 2005-2025.* It anticipated an increase in the population of people with learning disabilities and in the proportion of people with complex support needs.

There were 318 patients at Muckamore Abbey. It was determined that the number would be reduced to 87 by 2011.[4]

During **2006**, a 35-bed admission and treatment unit was opened, and a 23-place forensic unit was close to completion. These cost £8.4m.

Muckamore Abbey Hospital comprised three populations:

- Assessment and Treatment
- Resettlement
- Delayed Discharges.

During **2011**, *Transforming Your Care* was published. This urged the completion of resettlement from long stay hospitals and highlighted the need for a new service framework setting out standards of care for people with learning disabilities.

The Regional Community Integration Project was established to implement the Department of Health's regional strategy/Bamford vision that "no-one should have a hospital as their home." The strategy identified 235 Priority Targeted List of patients (PTL) at Muckamore Abbey who should be offered homes of their own outside of the hospital environment.

[4] In December 2011, there were 225 patients at Muckamore Abbey Hospital

During 2012 – to date, 188 of these patients have been resettled leaving 14 patients from the PTL still to be discharged. As a result, the following wards were closed - Finglass, Greenan, Rathmullan, Oldstone, Ennis, Mallow, and Moylena. Only one resettlement ward remains open – Erne.[5]

During **2014**, the Northern Ireland Assembly's Health Committee reviewed *Transforming Your Care*. This focused on disability discrimination and the promotion of people's physical health care.

During **2016**, the Mental Capacity (Northern Ireland) Act sought to bring mental health and mental capacity law together.

Montgomery and Armstrong assert that the Muckamore Abbey was built at the end of the era of institutional care to an obsolete colony plan. However, after becoming a model to be emulated in the 1960s, it began to decline in the 1970s and 1980s when it became understaffed and overpopulated. During Muckamore Abbey's history it is acknowledged that too much emphasis had been placed on the development of large hospitals with the result that the development of community services was neglected. People with learning disabilities and their families lived with the shortcoming of there being no alternative. The expansion of the hospital ceased at the end of the 1970s when disconnection from community services was mandated and underfunding and overcrowding persisted. It was increasingly an isolated hospital, serving people with a considerable range of support needs. Muckamore Abbey resettled patients during the 1980s and by the 1990s, the fabric of its buildings was deteriorating, and major investment resulted. The authors accepted (in 2009) that specialist community services and progress in resettling patients was unfinished business.

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[5] Update provided by RO14

Appendix 3

The Hospital's safeguarding files

The following seven Tables[1] set out the principal allegations of patients or concerning patients and the outcomes arising from the allegations. If "History of Making Allegations" is cited in a patient's file, this is reflected in the column HMA.

Table 1 The allegations and outcomes (a)

Year	Ward	Allegation	HMA	Outcomes
2013	Erne	Staff pulled hair; staff tore up cigarettes	*	2 staff always present; case closed
2015 2017	Erne Killead	Unnecessary chastisement from staff; angry at being woken - alleged staff hit patient; having hit staff member stated that would inform relative that staff hit patient	*	Patient said it wouldn't recur and wanted this to be known to family; "screened out x 2;" 2 staff to be present when argumentative
2016	6 Mile	Staff assault; alleged staff kneed in groin		Patient does not wish any action; staff not to work with patient, case closed
	Ennis	Patient alleged staff hit peer		Peer stated allegation untrue
2014	Cranfield	(historical?) abuse		Patient had received financial compensation; "no evidence or substance"
2014	Killead Cranfield	Staff burned patient in bath; alleged staff pushed patient to floor; staff put hands around patient's neck	*	Staff not to be alone with patient; patient stated had been "telling tales" - allegation unsubstantiated
2016	6 Mile	Staff held patient around neck during a scuffle		Staff member not to work with patient and should have carried an alarm
2015	Cranfield	Staff witnessed colleague rough handling/ shaking and pushing a patient		Staff member referred to PSNI
2016	Cranfield	Sexual assault and physical assault by relative and relative's partner		Relative advised to visit alone; visits supervised; 2:1 staffing
2014	Killead	Name calling by staff	*	Staff denied allegation. 2:1 staffing and staff implicated will not work with patient

Potential explanations surrounding the allegations are given coverage in some files e.g. "X's health is poor…may be one factor…unsettling issue may be his proposed move to nursing home// …has a difficult relationship with staff member and has made comments in past…doesn't want staff member to work with [patient]// …very agitated and requested PRN//…eventually decided. did not want police involved, *I don't know what to do for the best. What should I do?...I'll drop it, I'm tired…I don't want to do anything. I just want to leave it. Will it not happen again? //* Relative gave three accounts of what happened// relative says that [allegations] X's *normal avoidance behavior."*

[1] For ease of reading these have been grouped in blocks of 10 per table

Table 2: Allegations and outcomes (b)

Year	Ward	Allegation	HMA	Outcomes
2017	Cranfield	Angry at being woken, refused meds		Do not touch X when waking X
2014	Killead	Pushed by staff – retracted allegation		?
2014	Erne	Staff observed staff push patient who hit head on floor		First aid to patient, staff suspended and PSNI informed
2013	Cranfield	Patient told relative, had been pushed by staff		Patient stated that *it's just guys trying to have fun…don't worry about it*
2012 2013	Oldstone	Staff called patient "lying bitch;" staff pushed patient resulting in fall	*	Screened out; unsubstantiated allegation – staff not to work alone with patient
2013	Donegore	Staff pulled patient's hair		*No substance to allegation*
2016	Cranfield	Staff pushed patient		Didn't meet criteria. Staff member not to work with patient…to be followed up by community colleagues
2016	Cranfield	Overheard telling relative that staff had pushed her head into glass window		?
2012	Oldstone	Patient had been uncooperative and disruptive - Staff had punched chest saying "Go away;"		Patient wanted PSNI involved; asked to say yes/no it happened/ did not happen – patient "scared that staff will get in trouble if says yes"
2016	Moylena	Punched and sworn at during physical intervention	*	Staff x4 present – allegation unfounded

Potential explanations included, "…has long forensic history…anxious about community placement// agitation and distress have increased// unsettled."

Table 3: Allegations and outcomes (c)

Year	Ward	Allegation	HMA	Outcomes
2014	Donegore	Staff bullying patient		Relative contacted the PSNI; was reassured by Hospital of the context
2015	Donegore	Staff bullying patient	*	No concern
2013	6 Mile	Thrown against wall by staff		? Illegible handwriting
2017	Cranfield	Relative states patient has bruised wrist		Rejected; 2:1 staffing in bedroom
2014	Greenan	Staff verbally and physically aggressive to 2 patients		PSNI contacted, Protection Plan in place
2013	Oldstone	Patient hit by staff	*	Patient apologised. Staff moved as part of Protection Plan
2013	Ennis	Staff nipped patient during physical intervention		?
2016	Erne	Staff name calling		Rejected
2013	6 Mile	Staff swearing at patient		Screened out – *happy with outcome*
2013	Cranfield	Staff hit and abused patient		? Illegible handwriting

Explanations included, "Staff gave another patient a hug, didn't give the patient one// *the doctors and nurses push me around…the staff annoy me//* very unwell at present."

Table 4: Allegations and outcomes (d)

Year	Ward	Allegation	HMA	Outcomes
2013	Ennis	Staff hit patient	*	?
2017	Killead	Staff hit and kneed patient		Increase of supervision, 2:1…threshold of adult in need of protection has not been met…screen out…meets the criteria for not referring to PSNI
2013 2014	Donegore	Staff called patient names; staff had tapped hand; was refused a hot drink and told to "F off"	*	Retracted allegation; staff confirmed patient was not tapped – not to be alone with patient in bedroom; Care plan in place
2014	Moylena	Staff dragged and pushed patient to toilet - given dry shave *in inappropriate manner*, opened bowels in shower		PSNI recommended prosecution re assault/ ill treatment - staff member plus witness resigned. Adult safeguarding process…NFA re adult safeguarding. Time lapse in reporting incident
2013 2015	Cranfield	Complained (?) about being hurt during physical intervention. Had been destructive and aggressive, *high level hold;* patient subject to physical intervention during which bruising occurred. Had been threatening to self-harm and attack staff		PSNI – *insufficient evidence;* ?
2017	Cranfield	Staff member observed to tip patient out of chair to *prompt* patient to have dinner		PSNI advised *no crime…does not meet threshold of serious harm under new policy*
2012	6 Mile	Shoulder scratched by finger nail by staff *prompting* patient to get up		Staff member moved…*has not requested the need for PSNI involvement or further investigation*
2016	Cranfield	Bruising sustained from staff…*not making a complaint*		Rejected, *does not meet eligibility criteria and staff witness…state the incident did not happen*
2012	6 Mile	Required physical intervention having assaulted staff. Apologised and claimed staff member *started fight*		Rejected…screened out
2013	Ennis	Relative reported patient allegation that staff hit patient	*	Staff no longer in employment

Explanations included, "Being treated for psychotic illness// Relative does not wish police involvement// patient's perceptions of situations can be confused// distressed that children were freed for adoption// unsettled."

The references to complaints suggest that an allegation may be directed to a process other than safeguarding.

Table 5: Allegations and outcomes (e)

		RO14 [redacted]		[redacted]
[redacted]	[redacted]	[redacted]		[redacted]

Explanations included, “Staff can be offered training/ support// concerns raised about *staff attitude and physical interaction//* patient’s *agitation and imminence of move to the community// very influenced by what patient sees on TV//… no positive behaviours were being shown by this staff member…empathised with the service users as to how they might feel being the victims of it// patient had been unsettled// behavior deteriorated recently…may be worried re future accommodation.”*

A ward sister expressed concern about *this standard of unsafe and ineffective care, not to mention lack of compassionate care…culture and attitudes.* The importance of communicating with and debriefing relatives was noted, particularly *if they witness any distressing incidents.*

Table 6: Allegations and outcomes (f)

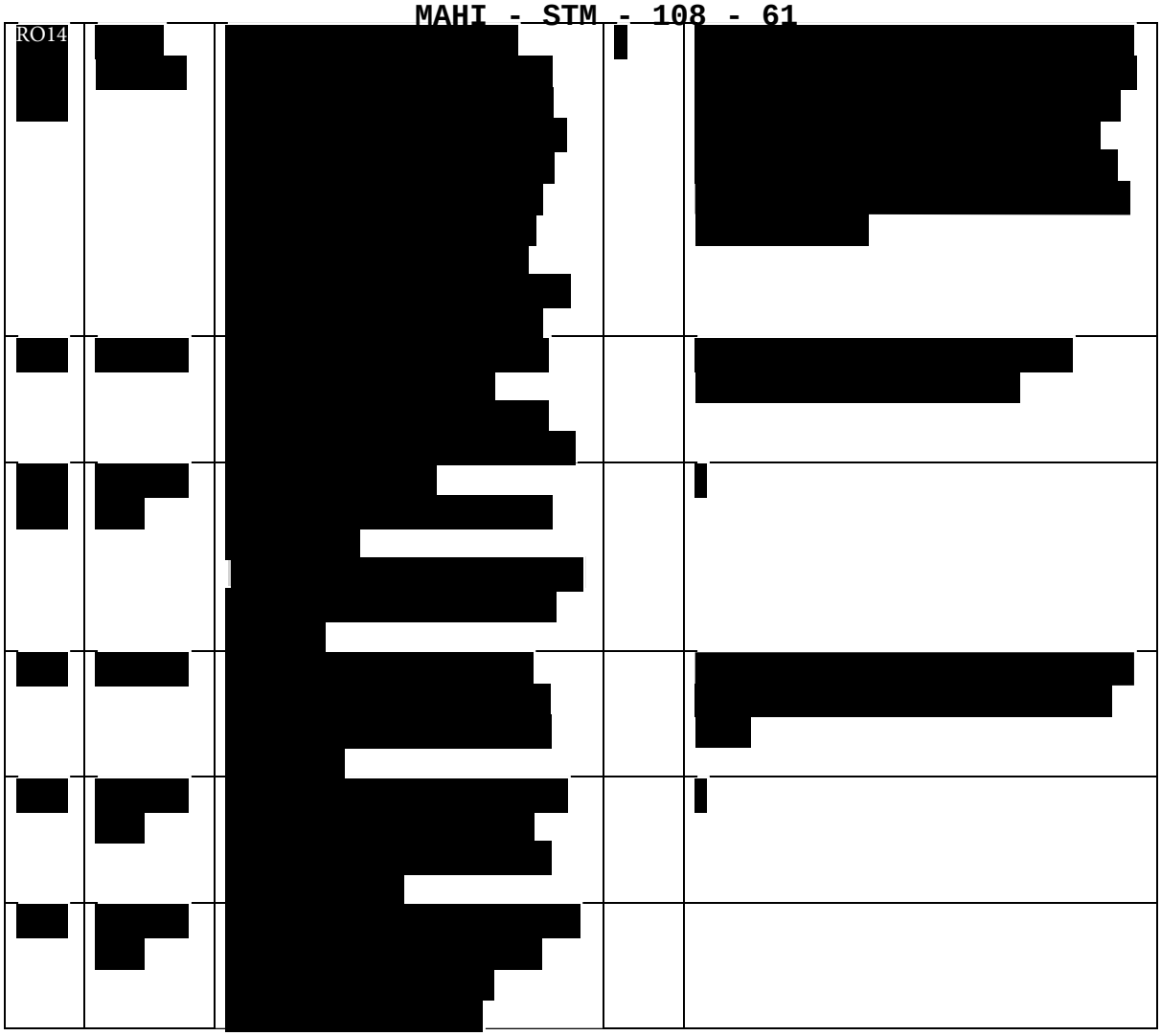
RO14 [redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

		patient on chest; staff hit patient; staff hit patient…*sorry for telling lies*; staff nipped patient; staff hit patient; pushed patient		hours; relative remained to assist in settling patient; screened out; false allegation as 3 staff present; ring relative if patient unsettled; a lot of these incidents can be dealt with quickly; referral to PSNI; allegation unsubstantiated; relative complained; screened out of safeguarding; accompanying staff confirmed untrue; relative does not wish to make 3rd party complaint – screened out…satisfied with protection measures; no injuries consistent with being pushed
2014	Moylena	Staff hit patient	*	Staff moved…2 members of staff have been removed…very upset; family group discussion; liaison with PSNI – agreed NFA; risk of false allegations managed with 2:1
2012 2013	Ennis Donegore	Staff used *inappropriate language* and feigned hitting patient; staff *assaulted* patient; staff sits on patient x2; staff hurt patient's *boobs*		Staff suspended – not to work bank shifts; relative does not wish to make 3rd person complaint; PSNI informed, Protection Plan in place…activity schedule to commence; relative does not wish to make 3rd person complaint; skin irritation under breasts/ prone to rashes; 2:1 during personal care
2013	Cranfield	Patient held up against a wall by staff – 16 years ago		Relative *does not wish to make a complaint*

Explanations include, "fluctuating mental health can limit patient's understanding// does not take responsibility for actions// patient has learned that if they make allegations then staff are *swapped out//* patient's new ward means *he is closed in completely//unfamiliar staff…day staff covering night shifts…staff shortages…other patients discharged."*

Table 7: Allegations and outcomes (g)

Year	Ward	Allegation	HMA	Outcomes
2014 2015 2017	Donegore	Historical abuse claims; staff told patient to "F off, go away"	*	2:1 for intimate care, staff have *heightened awareness.* Relatives believe patient was historically abused…no evidence/ investigated by PSNI – family have long standing concerns re effects of meds – suggested that staff should be told *to be better people and stop doing sneaky things to wind up patient;* relatives do not wish to take allegation further – screen out
2017	Cranfield Killead	Staff raped patient – retracted; staff hit patient – latter wants to *run away and kill self*; staff hit and dragged patient – retracted; staff raped, hit and declined to give patient food; staff hit patient - retracted	*	No staff alone with patient; on 2:1 to protect patient and staff; refers to historical incidents…screened out of safeguarding; leading questions should not be asked…walking away when patient distressed feels like rejection; referral does not meet threshold of an adult in need of protection…screened out
2012 2013	Greenan	Staff hit patient's head – retracted; staff twisted patient's arm	*	This would not be RQIA notifiable; relative does not wish to take further action..2:1 when attending to patient's hygiene



Explanations include, “patient wants the police to get patient out of the Hospital// mental health has deteriorated in the last few months// patient wanted a befriender// has been requesting PRN.”

Appendix 4

Workforce Issues at Muckamore Hospital

1. During discussions with various staff groups the Review Team heard repeated reports, particularly from Ward Managers and Team Managers, of their concerns around staffing levels and the ability to recruit and retain the required number of qualified staff to provide the care necessary to meet the needs of a hospital inpatient population. That is, a population which presents with ever increasing health and behavioural challenges and complexities. To gain a greater understanding of this concern the Review Team decided to explore this issue a little further and were kindly assisted in this task by senior hospital staff and representatives from Human Resources who provided the additional information requested.
2. Nurse staffing throughout Muckamore is viewed by many staff as a persistent challenge with a perception that ward staffing complements are insufficient to meet need. It should be noted at this point that little evidence was provided that shortfalls in care resulted and Nurse Managers have provided the Review Team with ample evidence of the ongoing attempts to recruit trained staff. The Review Team was told that nurse staffing shortages at Muckamore were identified as a risk and featured in the Trust's corporate risk register.
3. The Trust continues to use several strategies to recruit both Registered Nurses, learning disability (RNLDs) and Health Care Assistants (HCAs) to Muckamore, including open recruitment and recruitment fairs, advertised through social media with some success. Data provided by Human Resources suggests that the hospital consistently carries several funded vacant posts. The Review team accepts that, as yet, there is no agreed regional normative staffing model for learning disability nursing, however, there was no evidence of any systematically applied objective assessment methodology of staffing need at Muckamore that could draw some accepted conclusion on the staffing shortfall.
4. Successive RQIA inspection reports have raised the issue of staff shortages, although the Review Team did not see any evidence that this matter was raised with the Trust beyond the parameters of the individual ward inspection.
5. Variables to be considered when reviewing staff recruitment and retention issues include (among others):
    - Regional demand and supply of appropriately qualified RNLD
    - Time taken to recruit to vacant positions
    - Age profile of the existing workforce and the impact of potential retirement in the next 3-5 years
    - Ability to retain staff through attractive career development opportunities and progression
    - The impact of sickness and absence on current staff profiles
    - Reliance on the use of Bank and Agency Nurses to fill vacant positions

6. While recognising that all these issues are inextricably linked and consequently collectively impact on staff complements in Muckamore, the Review sought to tease out some of the challenges in each area.

Regional Demand/Supply of RNLDs

7. The Trust does not wait until posts are vacant to commence a recruitment process for RNLD posts. An open recruitment process is in operation so that RNLDs can apply at any time. The Trust combines this with Job Fair recruitment days advertised through social media targeting RNLDs for Band 5 posts and Health Care Assistant posts at Band 3. While this process has been successful in attracting staff it is notable that the Trust has not been able to recruit beyond the established number of funded posts. This approach is adopted by several Trusts in Northern Ireland, who experience similar problems recruiting RNLDs, which is indicative that the region is not training enough RNLDs to meet service demand. Additional training places have been commissioned (10 extra RNLD places for 2018-19).
8. ***The Review understands that this increase is only for one year and is not yet intended to be recurring. This small and one-off increase, while welcome, will be quickly absorbed across all Trusts in Northern Ireland and will do little to relieve RNLD vacancies at Muckamore.***

Time taken to Recruit to Vacant Posts

9. Like other Trusts, the operation of recruitment to vacant positions at Muckamore is undertaken by a shared service provided by the Business Services Organisation (BSO). The Review heard how this process has led to a delay in recruiting to posts, prolonging the period posts remain unfilled, with a sense of the Trust's lacking control over this issue and little indication of improvement. The view expressed to the Review Team was that it is unlikely that responsibility for recruitment would return to the Trust however, there is a real sense that unless significant improvements are made to BSO recruitment processes the likelihood is that delays in filling vacant posts will get even longer.

Age Profile of existing Nursing Staff

10. The Review understands that the age profile of the existing nursing workforce at Muckamore indicates that there is potential for many skilled and experienced staff to retire in the next few years. This is not unusual, although when combined with a sense that younger staff don't stay at Muckamore more than a few years, it leads to real concern that the nursing workforce at Muckamore will be the youngest and most inexperienced group of staff to provide nursing care for an inpatient population with increasing health and behavioural complexity.
11. ***Given the Review Team's conclusion that the role and function of Muckamore needs to be reconsidered and refocused with the objective of hospital admission only for assessment and treatment, combined with an understanding that the future population requiring hospital based care will be even more complex and challenging, there is a greater urgency to ensuring that the staff at Muckamore are equipped with the necessary skills/experience and appropriately supported to manage these challenges***.

Ability to retain staff through attractive career development opportunities and progression

12. Muckamore is no different in many respects to all other Learning Disability Hospitals in Northern Ireland in the context of the success of the 'resettlement programme' for people that were living long term in hospital. Wards have closed, and many staff moved to community services.
13. The historical nursing career infrastructure that was inherent in the older institutions has dissipated with the changing service profile. Consequently the opportunities for career progression at Muckamore are fewer and less frequently available. Following registration, younger staff take up positions at Muckamore to gain experience and generally after 2-3 years move to community services where career opportunities appear more attractive and accessible.
14. Whether staff shortages and the perceived lack of development opportunities at Muckamore influence this migration out of hospital would need to be tested further. Nonetheless the Review Team was told that staff shortages frequently mean that prearranged training and development programmes have been cancelled at the last minute to maintain safe care on the wards.
15. ***Provided an agreed future service purpose for acute inpatient care for adults with a learning disability can be agreed, then plans need to be in place with immediate effect to retain nursing staff which includes providing them with a sustainable programme of continued professional development directly linked to the needs of the service user group requiring a period of hospital care. To retain staff, consideration needs to be given to developing promotion opportunities for hospital staff, including more specialist roles embedded in ward teams rather than separate. Such roles must have a clear evidential base in terms of the benefit to service users and be linked directly to Continuing Professional Development (CPD) opportunities.***
16. There is evidence that the Trust has invested in staff to undertake further education programmes to acquire a recordable specialist nursing qualification. ***However, these staff have returned to the substantive positions that they held prior to acquiring these new skills, and consequently are not always working in a dedicated role that allows them to use their specialist skill to benefit service users and lead on nursing practice development.***

The impact of sickness and absence on current staff profiles

17. Sickness and absence rates for nursing staff at Muckamore consistently run at 7% or over and exceeds that of any other professional group. This is particularly high and, combined with the number of vacant funded posts, clearly adds to the pressure of maintaining adequate staffing levels on wards and increases the need to replace absent staff through bank and agency nursing. This issue is not unique to Muckamore and the Review team was informed that the Trust's Management of Absence Policy and Procedures were followed.
18. ***Nonetheless given the challenges in maintaining staffing levels at Muckamore, the Review Team suggests that the Trust and senior hospital managers, in partnership with staff side representatives, may wish to consider how absence management could be strengthened***

and more robustly managed and monitored to reduce the impact and cost of lost nursing hours on service provision.

Ratio of RNLDs (Registered) to HCAs (Non-registered) Nursing Staff

19. Nursing staff ratios of registered nurses to non-registered nursing staff is recognised as one of many indicators of the quality of care. If all funded nursing posts in Muckamore were filled the ratio of registered to non-registered staff would 49%/50%. The Review team acknowledges that registered to non-registered nursing staff ratios are very fluid and can vary from day to day and clearly is affected by the difficulty in recruiting staff to fill vacant funded posts. As a result of these challenges the ratio of registered to non-registered nursing staff across the nursing workforce in the hospital has dropped to 38% registered to 62% non-registered staff. This is an average figure taken at a point in time (31 June 2018); therefore it is reasonable to conclude that daily this ratio can change considerably in individual wards across the hospital. This figure is concerning given that the inpatient population of Muckamore, at any one point in time, is considered as the most challenging and most complex, including those whose discharge from hospital is delayed because suitable supported community accommodation to meet their needs cannot be identified or secured. Although there are no empirical studies addressing safe staffing levels, there are factors which are known to impact on the delivery of safe and compassionate care, that is: people's support needs; staff attributes; staff perceptions of challenging behaviour; working as a team; job satisfaction; work overload; organisational support; and working in the community for example.[1]
20. It is not clear that Muckamore has an agreed preferred registered to non-registered nursing staff ratio, although a preferred ratio of 70% registered to 30% unregistered is not unreasonable for the complexity of need presented by those admitted to Muckamore. Although this ratio is perhaps unrealistic or unachievable, a 48%:52% ratio should raise questions about (i) the ability of registered RNLD staff to adequately lead and supervise the work of non-registered staff who are delivering most of the direct patient care interventions and (ii) the capacity of this workforce to champion people's health improvement, enhance their well-being and enable them to leave the hospital and enjoy full lives after discharge.[2]
21. ***It is unlikely that the registered to non-registered nursing ratio at Muckamore will change significantly in the next five years and therefore there is an immediate need to invest in education and training of the Band 3 Health Care Support workforce which will continue to provide much of the direct patient care. This should be combined with a serious effort to reduce the administration burden placed on registered staff to afford them more time to plan and supervise care, to ensure the appropriate availability of knowledge and skills to***

[1] National Quality Board (2018) *Safe, Sustainable and Productive Staffing - An Improvement Resource for Learning Disability Services: Appendices*

[2] Department of Health, Department of Health, Social Services and Public Safety, Welsh Government and The Scottish Government (2012) *Strengthening the Commitment: The Report of the UK Modernising Learning Disabilities Nursing Review* Edinburgh: The Scottish Government

meet the increasing health and behavioural complexity of need of the projected future population who may require inpatient care.

Note: The Review Team recognises that while registered to non-registered staff ratio is one of many indicators of the quality of care, a low ratio of registered staff was not a factor in the PICU where the initial patient safeguarding incidents arose.

Use of 1:1 or 2:1 Observations

22. During this Review the Team read all the safeguarding files for the time period of 2012-2017. It became apparent that the customary response to allegations of abuse made against staff by patient(s) resulted in the implementation of 2:1 observations; to provide witness to any further allegations made by the individual about a member of staff. On the face of it this appears to be a defensive and expensive response to the issue that serves more to protect staff than the service user. The number of occasions this was evidenced in the files suggests that this has become the accepted response, yet it creates an unfeasible demand for additional staff.
23. ***The use of observations was never intended as a safeguarding/protection strategy and there is little evidence of multi-disciplinary review of allegations to determine potentially more proportionate means of responding to allegations against staff, that seek to provide more positive interventions other than 1:1 or 2:1 observations. For example, being attentive to patient grouping and patients having full diaries of purposeful and negotiated activities – including physical activities.***
24. ***Apart from the creation of a significant demand for nursing staff the continued use of observations in this way becomes in a very short period, of little therapeutic value, intrusive and oppressive. Consideration should be given to developing and implementing more therapeutic and supportive interventions in such cases with a clear focus on multi-disciplinary review and accountability. Patients spend too much time doing nothing. With a few exceptions, people's boredom is tangible.***

Dependence on Bank and Agency nursing hours

25. Because of some of the issues highlighted above, Muckamore relies heavily on replacing unfilled nursing posts and shifts by commissioning additional bank and agency staff at considerable cost. The Review acknowledges that in many cases it is existing hospital staff (or retired staff) who volunteer to undertake additional hours on top of their existing contracted hours to fill vacant shifts. There is no doubt that without the commitment of these staff it would be virtually impossible to operate all the wards and maintain a service. However, this reliance on Bank hours has become the norm at Muckamore, like many other hospitals and Trusts in Northern Ireland. This phenomenon remains an unstable and unsatisfactory way to build and maintain consistent wards nursing teams that can collectively engage in and provide sustainable quality improvements.
26. An unintended consequence of the reliance on bank and agency staff is that current systems do not afford timely management and intervention when staff are scheduled to work hours

that take them beyond accepted legal requirements for adequate rest and recuperation, even for staff who have opted out of the European Working Time Directive. Ward Teams appear to struggle just to provide a safe service and have little opportunity to develop nursing practice. It is questionable whether staff who consistently work excessive hours become tired and unable to maintain the drive and enthusiasm required to work with service users in an optimally therapeutic way. To maintain a safe service the wards experience constant changes of personnel. This is disruptive to patients, it does not lend itself to the creative environments required for a stable nursing team to develop their nursing practice or to meet future complex behavioural complexity in the future.

27. The cost to the Trust of agency and bank hours had recurrently equated to a weekly average of 50 Whole Time Equivalents (WTE)

Average bank hours per week converted to WTEs	
2014 – 2015	59
2015 – 2016	53
2016 – 2017	56
2017 – 2018	43

28. Over the last four financial years the Trust has been spending at least to the equivalent of 50 WTE nurse per week on bank hours and therefore should by default consider this level of investment as unavoidable to maintain services at Muckamore. Arguably, the Trust should seek to recruit to this level in permanent posts to significantly reduce the reliance on Bank hours and create more stable and sustainable ward teams.
29. However, given the existing difficulties in securing staff it is unlikely that the numbers required will be available in Northern Ireland in the next five years. ***Reluctantly the Review Team recognises that this position for the Trust represents high cost and significant risk to quality of services as they are currently configured at the hospital. This position hastens the need to quickly decide whether Muckamore has a future. Identifying its future role and purpose within the context of assessment and treatment services is a matter of urgency.***

Appendix 5

Themes arising from Regulation and Quality Improvement Authority (RQIA) Reports 2012-2017 at Muckamore Abbey Hospital

Background

1. The Terms of Reference for the Level 3 Investigation state that the Review Team should review the effectiveness of "the implementation of previous recommendations following Serious Adverse Incidents, Adult Safeguarding investigations and RQIA reports…from 2012 – 2017."
2. A preliminary scrutiny of RQIA reports, including the associated recommendations and actions, suggested that the demands of tracking hundreds of recommendations and actions was substantial. An alternative approach was negotiated. In brief, the Team sought to identify the principal themes which Inspectors have addressed within a five-year time frame.
3. The twin tasks of inspection and quality improvement are perceived by most of us as straightforward. Belfast Health and Social Care Trust describes Muckamore Abbey Hospital as a provider of:

   > *"…inpatient, assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs or challenging behaviour…* [a] *full range of services are available including, psychiatry, nursing, social work, psychology, day services, behaviour support as well as Allied Health Professionals as required"*[1]
4. So, a hospital for adults with learning disabilities employs competent and experienced nurses and staff and, if it does not, the regulator will step in to help or protect the patients. This consideration of themes points to a different reality – inspectors requiring the hospital to act on the multiple recommendations associated with each inspection irrespective of the persistence of certain themes in RQIA reports.
5. The RQIA identify their responsibilities concerning "Mental Health and Learning Disability" as:

   > *…promoting good practice; preventing ill treatment; remedying any deficiency in care or treatment; terminating improper detention in a hospital or guardianship; and preventing or redressing loss or damage to a patient's property. We talk directly to patients and ask them about their experiences.*[2]

What we did

6. On 30-31 January 2018, two reviewers determined some rules of thumb to make sense of 61 RQIA reports of announced and unannounced inspections concerning ten Muckamore Abbey Hospital wards, some of which have since closed:
   - After a preliminary reading of a small sample of reports, identify some strong clues which may or may not be themes
   - Amend, develop or set aside the potential clues/themes based on the attention which the RQIA pays to them

[1] http://www.belfasttrust.hscni.net/LearningDisabilityService-MuckamoreAbbeyHospital.htm (accessed on 9 April 2018)

[2] https://rqia.org.uk/what-we-do/mental-health-learning-disability/ (accessed on 2 February 2018)

- Identify the "outlier" reports – the ones which stray from the more typical generic inspections
- One reviewer to read all the reports, a second reviewer to read over a quarter of the reports and two reviewers to read three, randomly selected reports to ensure the credibility of the emergent themes.

7. The reviewer who read all the reports invited the second reviewer to identify the potential themes. These were set aside until the first reviewer had finished reading all the reports and had identified evidence to confirm and strengthen each theme.

What we found

8. The inspection reports were complemented with 12 "Patient Experience Interviews" with patients and/or their representatives from all but two wards (Ennis and Iveagh) using a RQIA questionnaire. Most of these interviews took place during 2014. One was published even though no patients were interviewed. One stated that the questionnaire was *not completed due to patients' inability to verbally communicate and participate,* and another noted *no specific issues raised.*
9. The reviewers' scanning of the Patient Experience Interviews highlighted the following topics:
   (i) knowledge of advocacy/access to advocacy/involvement of advocacy (e.g. Greenan, Cranfield and Donegore)
   (ii) experience of restraint/rationale for restraint/hurt by restraint and relative not informed (e.g. Greenan, Cranfield, Killead and Iveagh[3])
   (iii) experience of seclusion/rationale for seclusion (e.g. Donegore, Cranflied and Six Mile)
   (iv) anxiety about leaving the hospital/delayed discharges (e.g. Oldstone)[4]
   (v) desire for activities/structured programmes/getting out and about (e.g. Cranfield and Six Mile)
   (vi) feeling safe/noise (e.g. Killead and Six Mile)
   (vii) change/no change resulting from expressed concern (e.g. Erne)
   (viii) not enough staff/too many staff (e.g. Six Mile)
   (ix) therapeutic wages (e.g. Six Mile)
   (x) food (e.g. Six Mile) and
   (xi) the removal of possessions such as mobile phones, razors and lighters (e.g. Six Mile).
10. It would be inaccurate to identify (i)-(xi) as themes since they derive from an RQIA questionnaire. Although inspectors undertook to ask hospital staff about some of the matters identified by patients, it is not known what changes, if any, the Patient Experience Interviews brought about.

[3] Iveagh is a Tier 4 children's service on a different site providing specialist in-patient, assessment and treatment services

[4] *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* http://www.belfasttrust.hscni.net/LearningDisabilityService-MuckamoreAbbeyHospital.htm (accessed 9 April 2018)

Table 1: The number of inspection reports for ten wards

Wards	2012	2013	2014	2015	2016	2017
Ennis*	2	2				
Cranfield	1	2	1	4	1	4
Greenan*	1					
Moylena	1		1	2	1	
Iveagh	3	3	4	1	1	1
Oldstone*		2				
Donegore		1	1	1	1	1
Killead			2	1	1	2
Erne			2	1	1	2
Six Mile	1	1		2	1	1

*These wards have closed

11. The following Table considers the backdrop to RQIA inspections and the different types of inspections. They typically indicate the reason for inspection as follows: A = an announced inspection; Un = an unannounced inspection; C = a complaint investigation; WB = triggered by whistle-blowing; SC = triggered by incidents and/or "serious concerns"; * = inspection status not specified

Table 2: The origins and types of RQIA activity and inspections

Ward	2012	2013	2014	2015	2016	2017
Ennis	Un SC	Un x 2				
Cranfield	A	Ax2	Un	Un x 4	Un	Un WB SC x 2
Greenan	WB					
Moylena	A		Un	Un x 2	WB	
Iveagh	? x 2 A	Un WB A	Un x 3 SC	Un	Un	Un
Oldstone		A x 2				
Donegore		A	Un	Un	*	Un
Killead			A Un	Un	SC	Un SC
Erne			Un x 2	Un	Un	Un x 2
Six Mile	C	A		Un x 2	Un	Un

12. The 2012 **complaint** concerned the alleged bullying of a male patient. The complainant was a relative who had "been advised by a staff member." The patient reported to their relative that they were told "Your [relative] can't help you while you are in here." He reported feeling unsafe, being subject to sexual advances and witnessing patients' engaging in sex. His mental capacity was questioned. The staff did not believe the patient to be "under threat" and it was concluded that there was "no evidence to confirm [the] allegation that he was treated badly." The man's relative was not assured by the investigation. "There was no sense that advocates were proactively involved." The relative was excluded from the patient's protection planning process, the records were insufficiently detailed, and a family visit was curtailed by the ward. The relative noted that staff were "unwilling to record incidents that happened to [the patient] but they are very quick to record anything he does." The RQIA undertook "to monitor the safety, quality and care of patients at Six Mile and follow up the treatment and care provided to" the complainant's relative.
13. The "**serious concerns**" of **2012** hinged on the "alleged abuse" of patients on Ennis ward. The inspectors noted "the major potential for behaviour problems," the "history of low staffing levels…the appropriate complement of staff for the ward remains unclear…[the] significant number of vulnerable adult referrals" and the challenges in securing post-hospital placements for patients. The RQIA concluded that the "practice presence of advocacy" was required.
14. The "serious concerns" of **2014** concerned the involvement of the Police Service of Northern Ireland in the use of handcuff and leg restraints on a young person who was subsequently taken to a seclusion room. Meeting minutes concerning this event were unavailable. It was unclear whether (i) de-escalation methods had been employed prior to the restraint or (ii) formal debriefing had resulted. The RQIA noted the limited knowledge of staff concerning the management of behaviours which challenge and sought the improved governance of physical interventions, the use of seclusion and PRN medication. Among the RQIA's 35 recommendations was the drafting of a protocol "to define the circumstances in which the police should be required to assist staff to manage challenging behaviour."
15. The "serious concerns" highlighted during **2016** concerned patients' deteriorating physical health, overcrowding, staff shortages, noise levels, increasing incidents and the absence of activities for patients. The RQIA inspectors found "no evidence" of compromised health, overcrowding, staff shortages, noise levels or under-occupied patients. They acknowledged the increase in the frequency of incidents yet determined that these were "not disproportionate."
16. There were three "serious concerns" identified during **2017**: the first hinged on "unsafe staffing levels" which the RQIA deemed substantiated, "however, levels had improved due to a reduction in staff absence and redeployment." The second concerned "staff shortages" which the RQIA acknowledged "on some occasions." It found that noise levels were substantiated. There was no evidence of an increase in incidents. The third concerned patients unable to access Allied Health Professionals; unmonitored care and treatment and temperature control. No evidence was found to substantiate these concerns.

17. **Whistle-blowing** led to two RQIA inspections. One during **2013**, alleged that a young person was sleeping on a temporary bed in [Iveagh's] day room and that young people were using the beds of patients on home leave. The RQIA "urged…urgent priority to establishing a robust, tiered model of intervention in the community to ensure that Iveagh beds are used appropriately…need to consider a step-up/down unit to enable young people to receive alternative support."
18. The whistle-blowing of **2016** alleged that Moylena was "dangerously understaffed" and that standards of hygiene were wanting. The RQIA noted the changes in ward management arrangements, "including the unplanned absence of the ward manager…the resignation and imminent departure of the deputy ward manager" has resulted in "confusion/uncertainty."

The Emergent Themes

19. Incrementally, the RQIA's reports over five years point to consistent themes – two in particular comprise the backdrop: (i) "Visiting professionals expressed concern about the prolonged [delayed] discharge of many patients…felt they were exhausting all possibilities within their own remits but there was a greater issue outside the hospital" [Killead] and (ii) "Concern regarding people's access to physical health care screening" [Cranfield].
    (i) **Institutional practices** embrace the management of groups of patients who are perceived to have similar support needs or experience identical circumstances, e.g. "major potential for behaviour problems…difficulty in getting appropriate placements for patients…" [Ennis); "TV in protective storage…weekends long with few activities…Patient Forums sporadic and advocate not present" [Cranfield]; "dormitory areas…some [patients] have been on site for more than 50 years…outings off ward are limited…patients woken to get dressed at 6.00am to assist day staff…previously inspectors had been told it was patients' choice to get up early" [Greenan]; "routines…modified to ensure individual access to bathroom areas…open dormitory…little progress regarding privacy measures…patients' experience could be perceived as degrading …personal property contained in locked wardrobes (which patients could) look at in the mornings …patients spending majority of time in group rooms…absence of personal items…staff ambivalent about belongings/having pictures in bed space area…subject to the routines of the ward…partitions (in the dormitory) would make it difficult for patients to be observed by staff"[Moylena]; re the transfer of a young person to an adult ward, it was anticipated that a change in environment may be therapeutically beneficial… unclean patient equipment… patients to wear only their own clothing" [Iveagh]; "blanket restrictive practices…not appropriate" [Six Mile]; "noise levels can be disturbing…environment in need of upgrading...over-reliance on agency/bank staff" [Ennis]; young people being admitted "over agreed bed capacity" [Iveagh]; "they stopped the gardening programme without telling us" [Six Mile]; "physical environment not conducive to the patients' needs, particularly noise levels" [Killead].

(ii) The **workforce** embraces: **the staffing establishment** e.g. "staffing stretched…sick leave 5-5.5% average for the hospital" [Greenan]; "staffing appropriate" [Six Mile]; "reduced staffing levels…staffing deficits" [Oldstone]; "over-reliance on agency/ bank staff…insufficient staffing levels…current staffing ratio does not facilitate therapeutic interventions…increased staffing provided" [Ennis] "staff sickness/ turnover has led to extensive use of bank and agency staff" [Iveagh]; "staffing allocation had been supported by staff from another facility…night staffing levels vary" [Moylena] "sometimes there's a lack of staff" [Cranfield] "not enough staff…because of the observation levels" [Six Mile]; "staffing levels did not reflect the needs of the patients. Health Care Assistants are frequently left to supervise patients without the oversight of qualified staff" [Erne]; "staffing pressures…unsafe staffing levels…low staffing impacting on incidents…staffing levels appeared adequate to support the assessed needs of the patients" [Cranfield]; **staff preparation, training and supervision** e.g. "arriving without clear instructions about their placement" [Ennis]; "most staff trained in safeguarding…[Greenan]; "staff not supervised for five months" [Cranfield]; "all staff had received up to date supervision…not all mandatory training up to date" [Killead]; "Inspectors noted a lack of knowledge and understanding amongst staff team about how to address behaviours that challenge staff other than the use of restrictive practices…nursing staff can only attend mandatory training" [Iveagh]; **staff perceptions and experience** e.g. "We work in a demanding and stressful environment, but we have an excellent team of staff who provide a high-quality service to each child…number and nature of injuries to staff is unacceptably high" [Iveagh].

(iii) **Multi-disciplinary working** embraces: its **availability** e.g. "inequity of access to advocacy…no dedicated social worker for the unit…operating without the full range and availability of multi-disciplinary staff…a number of clinical specialists were not available…psychotherapeutic services not evident" [Iveagh] "no clinical psychologist attached to the ward…no OT input" [Cranfield]; "no pharmacy support on ward" [Iveagh] "insufficient managerial and clinical input to the ward" [Donegore]; "no evidence of input from Behavioural Support Services…in assessing behaviour and devising/overseeing management plans" [Ennis]; "medical staff not always available" [Cranfield]; **purpose**, e.g. "MDT were continuing to develop patient care pathways to improve patient experience and enhance therapeutic effectiveness" [Six Mile]; "MDT meetings…more focused on resettlement since 2012" [Ennis]; "clear evidence that psychiatrist and MDT had been advocating for the discharge of a patient" [Cranfield]; "Interdisciplinary Care Reviews had been reintroduced" [Iveagh].

(iv) **Purpose** at micro and macro levels: e.g. ward has a "resettlement focus" [Ennis]; "many patients have been receiving inpatient care for more than 50 years…no evidence of provision of activities or meaningful engagement with staff" [Moylena]; "continued admission was detrimental to individuals no longer receiving inpatient treatment…not in keeping with the philosophy, function and purpose of the ward"

[Six Mile]; "most patients are delayed discharges…managing frustrations" [Oldstone]; "the rationale or therapeutic aim…was not clearly documented" [Cranfield]; "difficult to carry out a monitoring role and be involved in nursing duties at the same time" [Ennis]; "some misunderstanding/differences about the purpose of [Iveagh] was evident;" "marked absence of an agreed, consistent, proactive behavioural management strategy…need to revisit the educational input to clarify the role of the visiting teacher" [Iveagh]; "I don't think the Team had a set plan" [Oldstone]; rationale/therapeutic aim not consistently recorded re restrictions [Killead]; transition back…not thought through" [Erne]; "difficulties in accessing extra contractual referrals for specialist treatment…range of patient profile and needs (impacts on) creating an appropriate therapeutic environment/recovery model…the introduction of a "sensory modulation room which patients could use to relax and listen to music…fibre optic lighting and massage chair…seclusion room being redesigned to include a low sensory area with the aim of reducing the number of patients requiring seclusion…difficult to track patients' progress" [Cranfield]; "goals should be recorded in care plans…there are smaller areas for patients to sit and form friendships" [Cranfield]; "in circumstances where people required enhanced observations, nursing care and team duties were prioritised over activities…some patients choose not to access therapeutic interventions" [Six Mile]; "patients had several sets of care files"[5] [Moylena].

(v) **Restrictive practices** embrace physical interventions, including restraint, secluding patients and administering PRN medication, e.g. "no evidence of restricted access or removal of patient's mobile" [Six Mile]; "hospital has been commended in the training and audit of physical restraint by BILD. Seclusion records were examined and reflected Trust policy…many of the restrictive practices in use were not documented…and were not under regular review" [Cranfield]; "evidence of some patients experiencing restrictions due to the needs of their peers…physical intervention audited…use of [planned] restraint for patient who required support to provide a blood sample…four staff involved yet care plan did not support this. No best interests discussion, no independent advocate" [Moylena]; "blanket restrictive practices…not appropriate [i.e.] locked doors, phone access, time off ward, personal

[5] The RQIA reports include references to over 25 types of assessment and planning tools: Comprehensive Risk Assessments, Risk Management Plans, Care Plans, Person-Centred Care Plans, Personal Activity Plan, Care Plans for Each Need Assessed, Positive Behavioural Support Plans, Individualised Incentive Plans, Patient Progress Records, Progress Notes, Assessment of Communicative Needs, Restrictive Practices Assessment, Individual Assessments for Therapeutic and Recreational Activities, Individualised Restrictive Practice and Deprivation of Liberty Care Plan, Discharge Care Plan, Care and Treatment Plan, Holistic Needs Assessment, Capacity Assessment, Best Interests Checklist and Decision-Making, Financial Capacity Assessment, Occupational Therapy Assessment, Swallowing Assessment and Hospital Passport. In addition staff use a Betterment Audit Tool, undertake Significant Events Audits, Braden Scale Assessments, Malnutrition and Universal Screening Tool, Risk Screening Tools, Promoting Quality Care Screening, Interdisciplinary Care Reviews, Management of Actual and Potential Aggression, Belfast Risk Audit and Assessment Tool, Functional Analysis of Care Environments Risk Assessment and Quality of Life Assessments

searches…Patients had signed their Restrictive Practices Assessment indicating that they had agreed to Restrictive Practices being used " [Six Mile]; "practices…that could be viewed as restrictive" [Cranfield]; "Explanation about the use of restrictive practices…detailed in Easy Read in the ward's Welcome Pack" [Donegore]; "patients did not have access to their bedrooms and personal belongings during the day…all patients are subject to the same level of restriction…locked doors and covert medication" [Ennis]; "Inspectors noted a number of referrals that could be viewed as restrictive but rationale/therapeutic aim not documented…new pro forma to record episodes of seclusion…no evidence that capacity to consent to care and treatment was being considered…no explanation why episodes of seclusion had significantly reduced over past months" [Cranfield]; "observation levels, alarms on bedroom doors – restrictive?" [Killead]; "the practice of locking patients' wardrobes and chest of drawers had been stopped and all locks removed" [Erne]; "not all staff had received training in restrictive practices" [Moylena]; "incident re use of restraint and seclusion (re police involvement using leg restraints and handcuffs)…patient was transferred to a seclusion room using a bed sheet…Inspectors noted a lack of knowledge and understanding amongst staff team about how to address behaviours that challenge staff other than through the use of restrictive practices…informal discussion (followed these) incidents…no evidence of any learning [Six Mile]; "There were 120 incidents of seclusion in January 2014, 29 in June; 65 PRN in June…7 in July; 65 physical interventions in June, 19 in July …a significant reduction in interventions…staff confident in use of proactive strategies and motivated by…success…one patient stated they had been hurt" (during restraint)[Iveagh]; "bi-monthly restrictive practices meetings to discuss episodes of seclusion, PRN and other restrictive practices" [Cranfield]; "Rules are unfair. I'm not allowed out…reduction of seclusion use, physical interventions and PRN…staff actively problem-solving and implementing positive behaviour support plans" [Iveagh].

(vi) **Records and their maintenance** e.g. "comprehensive risk assessment does not have contemporaneous information… notes did not evidence consideration or discussion about vulnerable adult referral or recording in incident records" [Six Mile]; "seclusion rooms were examined and reflected Trust policy" [Cranfield]; "no specific explanation of monitoring role documented…unable to clarify how incidents reported" [Ennis]; "some information in care documentation lacked detail…documents about one patient noted a number of different behaviour support plans…documents about a patients noted that behavioural supports were not used (staff explained that the patient was) so autistic" [Cranfield]; "no protocol concerning in-hospital transfers [Iveagh]; "no ward based schedule for therapeutic activities" [Cranfield]; "no clear protection plans were evident…staff unaware where (these plans) are stored" [Ennis]; "Safeguarding officers are automatically alerted if more than three alerts are received for the same patient, however, does not alert safeguarding officers to multiple referrals due to same alleged perpetrator…care

plans and risk assessments not signed by patient or relative…rationale for some interventions not included in the documentation reviewed… care plans not person-centred" [Cranfield]; "care records were not formally audited…an overarching summary of each patients' psychiatric and medical condition was not available" [Erne]; "malnutrition assessments not being reviewed on a monthly basis… patient satisfaction survey bi-monthly" [Cranfield]; "Patient records were not stored securely…care plans not always up to date" [Erne]; "reviews did not always reflect if the restrictions had reduced" [Cranfield]; "care plans about actual or perceived Deprivation of Liberty did not evidence that the multi-disciplinary team had considered proactive strategies to reduce the use of restrictions" [Killead]; "although a safeguarding vulnerable adults protocol had been developed, staff were not correctly completing the documentation…patients had several sets of care files" [Moylena].

(vii) **Engagement with patients' families and advocates** e.g. "staff believed he had (mental) capacity…his mother believed he did not…did not feel informed about his care…family excluded from the protection planning process…unintentional that (a) visit impinged on family time" [Six Mile]; "a recommendation made to consistently inform relatives about incidents and vulnerable adult referrals to ascertain and record their views" [Cranfield]; "relatives to have more access to living areas…representatives said that they had never been informed or had any indication from staff that their relative had been hurt during a physical intervention (or that a seclusion ward was used)…advocates only available to see those subject to a Care Order" [Iveagh]; "informing relatives of the purpose of meetings in advance" [Erne]; "relative highlighted level of assistance given to relative and the consistency of care delivery across the staff team" [Cranfield]; "advocates occasionally attend meetings on the ward but do not routinely visit or spend time with children being assessed… [Iveagh]; "there's significant demand (for advocacy) but availability is limited due to funding" [Cranfield].

20. The endurance of these themes has not yielded to effective remedies thus far.

Response to Briefing Paper – Themes arising from Regulation and Quality Improvement Authority (RQIA) Report 2012-2017 at Muckamore Abbey Hospital

General Overall Comments

- RQIA would have welcomed sight of this paper being made available prior to the meeting with the review team so that we may have given informed comments at the meeting. (Report dated 9 April 2018: meeting convened 14 May 2018).

- We note that the Terms of Reference have not addressed all of the findings and recommendations, following inspections (para 1). Ww would welcome the opportunity to provide further information and context to the review team.

- There is no reference to RQIA inspection methodology, processes or procedures. There is no reference to the Mental Health Order (Northern Ireland) 1986 and MHLD's statutory functions. This seems incomplete as it does not set the context for RQIA legal and regulatory function with respect to services delivered in Muckamore Abbey Hospital (MAH).

- We would welcome some discussion/descriptor of RQIA's inspection methodology. The term 'typical generic inspection' is not familiar as our methodology takes into account additional indicators.

- RQIA would welcome the review team's clarification of the use of the term 'serious concerns'. This is an RQIA internal process that falls under our Enforcement Policy; subsequently the review team's use of this terminology is unclear to us.

- It is not clear as to what methodology the review team used to rate, catalogue and determine the themes.

- Patient Experience Interviews (PEI) are carried out in accordance with our legislative functions. We meet with patients in private and subsequently they are not a form of inspection, rather they are a core element of the overall inspection process.

- Whilst RQIA understand the review team is assessing safeguarding processes, this report fails to reference the positive experiences that the patients shared with inspectors during inspections and PEIs.

Section Comments

Page 1-Para **3.**	• RQIA undertake MHLD inspection in accordance with legislation and minimum standards for care and treatment. Any subsequent recommendations are followed up in accordance with RQIA's Inspection Policy.
Page 1-Para 3.	*"The twin tasks of inspection and quality improvement are perceived by most of us as straightforward."* • It is not clear what is meant by 'straightforward'.
Page 1-Para 5.	• RQIA would like clarification of this statement as staffing issues are largely related to commissioning and as such are the responsibility of DOH/HSCB. RQIA's inspection role is to identify and remedy any potential deficiencies in care and treatment. We would comment on the general theme of staffing and ask for attention and/or remedy. The role of protecting patients falls within the responsibility of a number of agencies. RQIA do not undertake safeguarding reviews although we do review safeguarding processes.
Page 1-Para 5.	• The report makes no reference to RQIA's Escalation and Serious Concerns Procedures, which have been invoked on 21 separate occasions. The section of the report is inaccurate given that RQIA have commissioned thematic reviews.
Page1-Para 7 (and supporting bullet points)	• Requires clarification regarding the reasoning behind the statement 'make sense of 61 RQIA reports'. RQIA's reports are public facing, written in clear and concise english, and are available in easy read versions. Furthermore, RQIA does not understand the term 'outlier reports' within the context of the report. We would welcome further clarification.
Page 2- Para 3:	• This paragraph suggests that we did not speak with patients. Please note, sometimes it is not possible when patients are very unwell, or, as in this situation, not capable of answering the questions. We have alternative approaches, usually involving observation and advocates.

Page 3-Table 2	• RQIA does not investigate complaints, but we do act in response to intelligence received and invoke our serious concerns processes.
Page 4-Para 2	• We would welcome clarification as to whether this relates to the Iveagh centre; it reads as if it was Ennis Ward? If it is Iveagh, RQIA undertook to work closely with this ward to improve standards and care practices. We would ask that our work is included/ reflected appropriately here. In July 2014 five Improvement Notices were issued, it is important to note however that was the only time RQIA's MHLD Team have taken this action following an inspection. • Regarding the improved use of seclusion and PRN medication, this statement can be interpreted in two ways, positively or negatively.
Page 5-Para 1.	• There has been no mention of any progress made following recommendations made, post inspection.
Page 5-Para 2	• RQIA note the report has not qualified the two major themes. These have not been developed fully. We are not clear, as it goes on to talk about different themes e.g. institutional practices. There is no reference to the successful implementation of previous recommendations, e.g. increased OT and Psychology levels on the wards following RQIA recommendations.
Page 6-Para 1	• The report does not provide the context in relation to staffing issues. There is no reference to variation across the hospital site, contingency planning, escalation, training improvements, supervision and environmental improvements. Again lots of reference to Iveagh which is a different facility providing a different level of care from the MAH.
Page 6-Para 3	• RQIA have addressed all these themes on a consistent basis during inspections (and follow up inspection) since 2012.
Page 7-Para 1	• There is no measure of the implementation of the recommendation despite this being the main purpose of the review.

Page 7-Para 2	• Restrictive Practice Sixmile Ward – we note there is no reference made to patients refusing to leave this regional low secure ward. We understand that patients are willing to stay voluntarily and the Trust supports this.
Page 9, final sentence - *The endurance of these themes has not yielded to effective remedies thus far*	• RQIA would not concur with this statement and contests that the findings presented in the report do not support this outcome. We would welcome evidence supporting this outcome determination.

Appendix 7

Health Needs

Changing demographics and population across the lifespan

The population of neonates, children and young people living into adulthood with a range of multiple and complex neurodevelopmental disabilities and learning disabilities is increasing.[1] There is an increase in the number of premature neonates surviving into adulthood who have a wide range of interrelated complex physical and mental health conditions and challenging behaviours.[2] [3] Many require invasive health procedures to sustain life and are more technologically dependent due to their co-existing physical health conditions.[4] This population are also presenting with neurodevelopmental disorders, including Foetal Alcohol Spectrum Disorder, Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder.[5] [6] [7] [8] [9] [10] [11]

Physical health conditions

Physical health conditions are common in people with learning disabilities and many remain unidentified and untreated with significant implications for the individual, their family and carers and care services.[11] Many people with learning disabilities present with a range of multiple co-morbid physical health conditions that if untreated leads to avoidable, premature deaths.[12] [13] The common physical health conditions experienced by many people with learning disabilities include, respiratory disease, cardiovascular disorders, endocrine disorders, neurological disorders, haematological disorders, infectious diseases, dermatological disorders, sensory impairments, sleep disorders and metabolic disorders.

Respiratory Disease

Respiratory disorders are the leading cause of death in the learning-disabled population, notably by way of chest infections, secondary to dysphagia, contributing to premature and avoidable death.[14] [15] Swallowing disorders are common and contribute to gastric aspiration and pneumonia and contribute to avoidable death.[16] Asthma is common, notable in those who smoke and are obese. Respiratory cancers associated with smoking are less common when compared to the general population.[17] [18] However some people with learning disabilities do smoke and access is required to programmes and support to quit smoking.[19]

Cardiovascular Disease

Cardiovascular disease is the second commonest cause of premature death.[20] Cardiovascular disease occurs at a younger age in adults with learning disabilities and a prevalence of 14% has been identified.[21] Cardiac and circulatory conditions effect 21% of adults with learning disabilities and contributes to premature death.[22] People with learning disabilities experience higher prevalence of hypertension, obesity and are physically inactive.[23] Coronary artery disease contributes to the premature death of older adults with Down syndrome.[24] Metabolic syndrome is now being experienced by people with learning disabilities, presenting with an increased risk of coronary heart disease and type-2 diabetes, with risk factors found to be

higher in young adults with learning disabilities.[25 26] In older adults with learning disabilities the prevalence rate was double that found in the general population.[27]

Epilepsy

Epilepsy is the most common co-morbid neurological condition experienced by people with learning disabilities. In a systematic review of the research evidence, an overall prevalence of 22% was identified. A prevalence of 12% was found in people with Down syndrome, which increased with age and in those with Alzheimer's dementia.[28] The prevalence of epilepsy increases with the severity of the learning disability. It is most prevalent in people with severe learning disability.[29] Epilepsy contributes to accidents and injuries and premature death in people with learning disabilities.[30] Access to assessment, diagnosis, treatment and management of epilepsy can be more complex in the learning disabled population due to other health co-morbidities, communication disorders and the range of complex seizures types that present.[31] There is evidence of an association between epilepsy and neuropsychiatric conditions, notably negative mood symptoms and are more common in those with severe forms of epilepsy.[32] Partnership working with primary care, paediatric and acute hospital services is necessary to enable investigations and diagnosis and at the point of transition between services.[33] Epilepsy management needs to be included in planning for discharge from assessment and treatment units to ensure that accommodation is appropriate, and the right levels of staffing support are in place.[34] As the number of children and young people with learning disabilities with complex health needs increases, there will be greater demand for assessment, treatment, psychoeducation and epilepsy management, including medication compliance.[35] Therefore, effective epilepsy management is needed and there are key roles for practitioners in specialist learning disability in-patient assessment and treatment units and community learning disability teams.

Gastrointestinal Disorders

Gastrointestinal disorders are common in people with learning disabilities and increase with the severity of the impairment, notably those with cerebral palsy and is associated with gastric-oesophageal reflux disorder (GORD), rumination, vomiting and hematemasis and anaemia.[37 38] Links have been identified between GORD, agitation, self-injury and rumination in people with more severe learning disabilities.[39]

Mental Health Conditions

Mental illness is common in people with learning disabilities, notably depression and anxiety and psychotic disorders, including schizophrenia.[40 41] Mental illness is also associated with developmental disabilities, including, ADHD and Autism.[42 43] People with learning disabilities are at greater risk of developing a mental illness due to a range of factors including, adverse life events, poverty and abuse.[44 45] Mental illness is also common in older adults with learning disabilities, with a high prevalence of dementia, which is particularly the case in people with Down syndrome.[46 47] Diagnosis requires access to specialists with knowledge and expertise regarding the different clinical presentation of mental illness in people with learning

disabilities and address needs related to communication disorders, co-morbid physical health conditions and diagnostic overshadowing.[48] [49] Despite the high prevalence of mental illness there remains a lack of access to appropriate psychological therapies for people with learning disabilities and this is an area that requires attention and investment.[50]

Offending Behaviours

Some people with learning disabilities commit offences and come into contact with the criminal justice system, with the prison populations comprising some 7-10% of people with mild learning disabilities.[51] Some people with learning disabilities are diverted from the prison system and receive treatment and interventions in secure health service settings.[52] Health co-morbidities are common in people with learning disabilities who offend and include, physical health conditions such as obesity, diabetes, sensory impairments and mental illness by way of anxiety disorders, depression, substance use and suicidality.[53] Other commonly occurring conditions include ADHD and Conduct Disorders.[54] In relation to women with learning disabilities who offend, long standing mental illness is common, including a major depressive illness, psychosis and schizophrenia, with polypharmacy being evident and need for access to psychological therapies.[55] There is a need to improve access to psychological therapies for people with learning disabilities who offend and are receiving treatment in health services secure settings.[56] Life events and trauma is also common in adults with learning disabilities which can result in PTSD and the need for access to assessment and treatment.[57]

Behaviours that challenge

Challenging behaviours are common in people with learning disabilities, with prevalence rates being between 10-15%.[58] Challenging behaviours include aggression, self-injury, agitation, destructive behaviours, arson and sexual misconduct.[59] Comprehensive assessment and treatment is required for challenging behaviour to identify and exclude untreated medical conditions and it is recommended that annual health checks are undertaken with people with learning disabilities[59] [60] Challenging behaviours have been identified in children and young people with rare chromosomal abnormalities.[61] A range of treatment options are required to support people with learning disabilities and challenging behaviours.[62] [63] There is limited evidence for the use of and effectiveness of psychotropic medication to treat challenging behaviour.[64]

Dementia

People with learning disabilities are at great risk of developing dementia, with a prevalence rate of 18% found in those over the age of 65.[65] Dementia is also common in people with Down syndrome, who develop the condition some three decades earlier than in the general population. By the age of 60, 80% of people with Down syndrome will have developed Alzheimer's dementia.[66] Both pharmacological and non-pharmacological treatments are recommended for people with learning disabilities and dementia, with implications for future health and social care services.[67] As the learning-disabled population ages and lives longer,

services will see more older people with dementia and other physical and mental health morbidities. Specialist services will be required to provide assessment, treatment and management of larger numbers of people with learning disabilities and dementia.[68]

Health checks and health improvement activities

Despite the research evidence of health needs and multiple health morbidities, people with learning disabilities need to access health checks and preventative care.[69] There is poorer uptake of proactive health screening, less uptake of national health screening programmes and prevention and health promotion activities when compared to the general population.[70] There are benefits to having a health check, including uptake of immunisations, cancer screening, the detection of treatable disorders such as thyroid conditions and the identification and management of dental and oral health conditions, dermatology conditions, gastrointestinal disorders.[71] Undertaking a systematic health check results in the detection of unmet, unrecognised and management of treatable health conditions.[72] Health checks lead to targeted interventions that improves the health and quality of life of the individual and their family and carers and reduces the burden on health and social care services.[73] Therefore, ensuring the comprehensive health check systems are in place in specialist in-patient assessment and treatment units and Community Learning Disability Teams is essential, particularly given the evidence of the increasing complexity of health needs and multiple health morbidities.

Supporting access to initiatives and activities directed at improving health and well-being is vital for people with learning disabilities and must be an integral part of specialist health service models and day-to-day practice.[74] People with learning disabilities need support to access national programmes available to the whole population, such as cancer screening. Health promotion programmes available for the general population need to be made accessible for people with learning disabilities, such as for the prevention of diabetes.[75] Activities focused on healthy eating, physical activity and weight management are required as an integral part of the care and support provided by universal and specialist learning disability health and social care services.[76] Where possible people with learning disabilities should be supported to access health screening and health improvement activities available to the whole population and where this is not possible due to the needs of the individual, person-centred and individualised adjustments need to be made.[77]

Multiple Health Morbidities

It is clear from the international research evidence that the health profile of children, adults and older people with learning disabilities is changing and the population increasing and ageing.[78] Many more young people are living into adulthood with multiple, complex health morbidities.[79] Collectively there is therefore a 'new generation' of children and young people living into adulthood with significant neurocognitive impairments and deficits and associated physical, mental health and challenging behaviours.[80] Older adults with learning disabilities are ageing with multiple, complex health morbidities.[81] [82]

The impact on services in the future

There are changes in the demographic profile of people with learning disabilities. The changes include increased longevity and changing patterns of morbidity and mortality. The last decade has seen a rise in life expectancy as in the general population, except for people with Down syndrome, epilepsy or multiple disabilities.[83] [84] Older adults are proportionally the largest and fastest growing group in the learning disabled population.[85] Life expectancy for an older person with a learning disability is now 70 years, with a projected 164% increase in the number aged 80 and over using care services by 2030.[86] The global increase in life expectancy is due to a number of factors including improved neonatal care and improved access to health and social care services.[87] Despite these improvements, many people with learning disabilities do not receive equal access to services and treatable health conditions remain undetected.[88] However, overall, life expectancy for people with learning disabilities remains 13 years lower for men and 20 years lower for women when compared to the general population.[89]

All education, health and social care services now and in the future will see more people with significant care and support needs of a different and more complex profile. Due to the interrelated complex physical, mental health and challenging behaviours, there will also be a growing and increasing demand for access to specialist care services, with assessment, treatment, interventions, care and support provided by highly knowledgeable skilled practitioners.[87] [88] [89] This growing learning disability population with multiple, complex health needs brings about new challenges for all health and social care professionals and care services. The planning and provision of quality healthcare is crucial to improving the health and quality of life. A long-term, strategic approach is required to build knowledge, skills and capacity within all health and social care services to meet future demands. The changes in the learning disability population will impact on all future service provision, including primary and acute care, emergency and unscheduled care, services for children and young people with complex physical health conditions, child and adolescent mental health services, specialist in-patient assessment and treatment services and Community Learning Disability Teams. There will also be a growing demand on specialist in-patient assessment and treatment services as the complexity of patients admitted changes and increases. It is therefore essential that there are a range of service and workforce responses in place to respond.

Due to their different pattern of health conditions from the general population, people with learning disabilities admitted to in-patient assessment and treatment services will require access to specialists with knowledge, skills and expertise to assess and treat a range of interrelated physical, mental health and challenging behaviours. As health and social care services are being redesigned and transformed to meet the changing needs of the wider population, so too must specialist in-patient assessment and treatment services and Community Learning Disability Teams. Investment in workforce, education, training and new service models is required.

From a specialist community learning disability team perspective, there will be increasing demands for assessment and treatment, interventions, education and supports for people

with learning disabilities, their families and carers. Arising from this is the increasing need for access to the knowledge and skills of psychiatrists, clinical psychologists, social workers, speech and language therapists, occupational therapists, physiotherapists, dieticians and learning disability nurses. It is therefore necessary to ensure that there are accurate long-term workforce development plans in place to ensure that there are professionals in place. Flowing from this is the need to ensure that there is the right level of commissioning of undergraduate and postgraduate students is in place, necessary to meet workforce needs in the future. Failure to recognise and respond will increase the health inequalities gap experienced by many of this vulnerable population and result in on-going system and service failures that contribute to poor outcomes and avoidable premature deaths.

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