ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Fiona Rowan
Date: 12 June 2024

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

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be "Exhibit 1".

Qualifications and positions

1. I am a qualified Social Worker (2002) and hold a degree in Psychology (1991). I have also completed a Postgraduate Diploma in Health and Social Care Management and a Diploma (HE) in Rehabilitation (1996) VI.

2. From September 2019 to June 2020, I held the position of Senior Improvement Lead (a temporary post, initially for 6 months) in Learning Disability in the Belfast Trust. It was agreed with the Director, Marie Heaney, that my role would be to focus on the resettlement process and I would provide information to senior management.

3. During a supervision in January/February 2020 Marie Heaney raised that Service Manager cover for Iveagh Ward (Children's inpatient facility for young people with a learning disability and mental health problems) was needed and it was agreed that in addition to my role in relation to resettlement, I would also act as interim Service Manager for Iveagh. I was employed as part of community services and worked across the different sites including MAH, Community Services and in 2020, Iveagh Ward.

4. In March 2020, my contract was extended for a further three months. In June 2020 Marie Heaney retired and I met with Tracy Kennedy (Co-Director) who advised that the resettlement position was not going to be extended.

5. While working as Senior Improvement Lead in Learning Disability I completed a number of reports in order to provide an understanding and insight into some of the challenges being encountered in the resettlement process and to identify areas for improvement. This was in light of a number of unsuccessful trial placements. The reports were relevant to late 2019 and early 2020 and were:

   - Proposals to Address the Barriers to Resettlement of MAH patients (Exhibit 1)
   - Transition Team Proposal February 2020 (Exhibit 2)
   - Summary of Learning from Unsuccessful Trial Placements June 2020 (Exhibit 3)

6. The first two reports were used to develop the presentation ‘Homes Not Hospitals - An Analysis of barriers and learning to support people with a learning disability and/or autism who display behaviours that challenge including those with a mental health condition’, that was presented to the Muckamore Departmental Assurance Group (MDAG) in February 2020 (Exhibit 4). Some of the documents have a draft watermark or are marked as a version. I can confirm that to the best of knowledge these were the final versions when I left my role as Senior Improvement Lead in June 2020.

7. I also completed work on a report in relation to Iveagh Ward and a report in relation to feedback and learning on delays with a statutory supported housing scheme.

8. Prior to taking up the Senior Improvement Lead position, I had been working for approximately 10 years (2010 - 2019) as an Assistant Service Manager and then Service Manager in Belfast Trust Community Mental Health Services. Both positions included the resettlement of mental health in-patients (as per Bamford), commissioned services (care management), community teams, forensic services,

early intervention team, resettlement team (which transformed to a Rehabilitation Team) and two statutory supported housing schemes.

9. My previous experience also included being a Care Manager in commissioned services (MH), Supported Housing Manager (MH), Day Centre Manager (MH), Home Support Manager (LD) and before qualifying as a social worker I had held a variety of social care posts in residential and support services in Learning Disability (approximately 8 years).

10. My responses to each of the questions I have been asked are largely limited to September 2019 – June 2020.

Module

11. I have been asked to provide a statement for the purpose of OM2024: Module 6 Resettlement.

12. My evidence is primarily concerned with paragraph 16 of the Inquiry's Terms of Reference.

13. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn.

Q1. Following the Bamford review of mental health and learning disability, how did BHSCT work with other agencies to ensure Bamford's general vision of resettlement in a non-hospital setting was realised?

How effective was any such inter-agency working?

14. Prior to my appointment as Senior Improvement Lead in 2019, my experience of ensuring Bamford's vision was predominantly as part of Mental Health Community Services. I had a general awareness of the pressures on Learning Disability discharges which was the vision for all long stay patients.

15. Upon my appointment in 2019, I was aware that the hospital and community services had already successfully re-settled large numbers of patients into the community. The Director confirmed that resettlement needed to progress as a priority and I began by looking at the process to identify areas for improvement.

16. The Trust planner, Maurice O'Kane, was in post in 2019 and this role supported services with planning for commissioned community services as proposed in Bamford's vision. The planner led on monthly meetings with providers and other Trusts for a number of supported housing schemes as part of the usual business planning process. This was the same process as followed by mental health services resettlement. I am unable to recall exactly when the planner went on long-term leave in 2020 (then retired) and the post remained vacant when I left in June 2020.

17. The planning role maintained oversight, momentum and business planning for supported accommodation. I identified and flagged that there were outstanding business cases, processes and required direction of travel decisions / agreement in order to plan and make progress, that these were time sensitive and this meant the accommodation process was slowed or on hold. Singleton bespoke accommodation packages and independent sector care homes were not included in that process.

18. The central multi-agency meeting was the Regional Learning Disability Operational Delivery Group (RLDODG), and this comprised of the Health and Social Care Board (HSCB), the Health Trusts, RQIA, and the Northern Ireland Housing Executive (NIHE). The group was co-ordinated by the HSCB. Carers were also involved who had experience from resettlements completed in other Trusts.

19. I noted examples of where inter-agency working was working really effectively, such as the Northern Trust Inspire project at Mallusk, which was a project managed through Inspire. Regular interagency meetings were held by Learning Disability commissioned services / care management and providers to explore new opportunities.

20. Inter-agency working and decision-making was affected by a number of different factors, these included patient assessments; changes in management; pressures within the services - including community teams; decision-making on potential proposals and developments; and the vacant post to support planning and business cases. From March 2020 Covid-19 also impacted discharges as lockdowns delayed visits, in-reach, out-reach work, staff availability. Work therefore continued within the regulations and guidance

Q2. What was the process for resettling a patient from Muckamore Abbey Hospital into the community? Please explain the process throughout the time period within the Inquiry's Terms of Reference, that is 02 December 1999 to 14 June 2021.

In answering this question, please describe:

i. What efforts were made at co-production with parents and relatives to ascertain patient requirements prior to their resettlement?

21. Prior to taking up the position of Senior Improvement Lead I had little direct knowledge of the process of resettling a learning disability patient from MAH into the community. My experience of resettling patients in mental health services was through a dedicated resource / team which provided an intensive model which enabled co-production through increased engagement and communication with service users, families and carers (this type of team is commonly used where the preferred model is for high intensity / low volume caseloads).

22. The resettlement process for Belfast Trust patients, was led by Learning Disability Community Services, which included Community Teams and the Care Management Team for the Belfast Trust, and it worked in partnership with the hospital staff. The process is described in the exhibits to my statement.

23. When I took up my post as Senior Improvement Lead in September 2019 there was a Community Integration Co-ordinator post. This person provided the link between hospital and community services with a regional co-ordination role and

reported to Belfast Trust Community Services and the HSCB on discharges. They were managed through the Service Manager for the Community Teams.

24. There was multi-disciplinary working between the hospital and community with the assessment and care management of discharges for Belfast Trust patients.

25. During my time as Senior Improvement Lead the community teams reported staffing challenges, which meant they had limited resources and capacity to do detailed and intensive levels of work. I asked about the use of tools such as person-centred planning or essential lifestyle planning (this is time intensive) which capture the service user's perspective and brings about co-production with family and carers. The Community Teams advised they were unable to provide that level of work.

26. An additional pressure on these teams was the absence of an intensive or crisis support community team. Community Teams were managing their community caseloads and the same community teams and care managers were responding to community crises. The Transition Team Proposal (Exhibit 2) at page 4 shows keyworkers in Belfast Trust community learning disability (as well as in mental health) had a higher average caseload size in comparison to other high intensity models / teams.

27. The hospital staff would also have been involved in transition work by providing outreach into the new setting. As with the Community Teams, when workforce pressures increased, the system was less able to provide this level of work. I saw examples where this worked really well and other occasions when staff who were agreed to go out had to cancel. This included situations where it was evident the hospital staff were really needed by the provider but the staff were unable to go due to staffing resources at the hospital. Examples of this are contained within the 'Summary of Learning from Unsuccessful Trial Placements' (Exhibit 3).

28. The discharge model varied between the different Health Trusts involved with discharging patients (see Exhibit 2 'Transition Team Proposal, Summary of Resettlement' pages 5-6 and 8-9).

29. Resettlement is a system wide process impacted by regional and local factors including policy, decision-making, resources (including staff, funding and placements), training and skills, communication, staff practice or 'ways of working', changes in management and the culture of the teams involved. This was in the context of the safeguarding cases, reputation of the hospital, pressures to close and pressure on time.

30. Resettlement appeared to be at a stage that what had previously worked well was either not consistently available (staff) or no longer sufficient for a number of the patients being discharged.

31. The community infrastructure to ensure an intensive support service to patients post discharge was planned but had not been developed, so without a developed community infrastructure for intensive support in the community the services were going to remain under pressure to meet needs in the community. A resettlement team or intensive support team would have offered intensive working during the leave on trial and post discharge stage and therefore this additional support was not always available.

32. Barriers to resettlement were identified (Exhibit 1) and a number of proposals were made and presented to MDAG. The Community teams and care management had successfully achieved a large number of resettlements, from a professional perspective and having experience of both models (mental health and learning disability), I believed that while the status quo could remain, a resettlement / transition team would address and improve many of the issues around the experience, quality, safety and effectiveness of the resettlement journey. A team with sufficient resources would ensure better communication, robust Trust assessments, care planning and transition work which included essential lifestyle planning and co-production. Details of this are contained within Exhibits 2 and 4.

33. On commencing my role in Learning Disability, I was provided with spreadsheets with discharge / resettlement plans. On further exploration, I realised that the lists were an identification of proposed placements and that the 'discharge plans' and placements were more tentative than the 'resettlement list' implied.

34. On realising staff had concerns about some of the discharge plans I encouraged staff to be open and that their concerns were critically important and it was safe to raise their concerns. In doing so staff were enabled to share and raise concerns with me about achieving the proposed resettlement plans. Staff described a pressure within the system that meant staff felt there was a requirement to have a discharge plan / destination and to include a date that was as soon as possible.

35. I was advised that assessments had taken place, however some of these had been part of more general scoping exercises and the formal pre-discharge assessments would benefit from more detailed comprehensive assessment and care planning with providers.

36. To ensure the gaps in planning, timescales and potential unmet needs were escalated I developed an Escalation List for senior management, and this high-lighted there was potentially unmet needs on the resettlement lists.

37. As an example of a proposed development, there was a proposed scheme on a site close to MAH, I became aware that the host Trust was not supporting the development and meetings continued where these destinations were being discussed as the actual discharge destination and these had to be flagged. The accommodation and linked resettlement plan for a number of patients included a proposal to develop a supported housing scheme in land adjacent to MAH, which is in the Northern Trust area. I understood from communication at the time that the Northern Trust were potentially not supporting this development. Meetings remained in place until the planner left post and during this time I raised within the Trust about decision making and the Northern Trust's position.

38. I was advised that some providers had previously been invited to come to the hospital and assess patients for their services. While independent providers do need to complete their own assessment in order to offer a service, the resettlement and all discharge processes should be led by the Trust completing a detailed assessment of need and the complexity of the case should be reflected in the assessment process. The gap being comprehensive and detailed Trust assessments. The next step is to identify which services/providers could potentially meet this need either on an individual basis or for several individuals who may have their needs met by one service. Any unmet need identified in the assessment process should be escalated for further decision making. I understood that the drive to support discharges also involves moving outside routine processes. However, in a small number of cases it became apparent that some pieces of relevant information or understanding of historical complexities were not known by the provider, leading to problems arising later in the discharge planning process.

39. The work on 'Proposals to Address the Barriers to Resettlement of MAH patients' (Exhibit 1) the presentation 'Homes not Hospitals' (Exhibit 4) 'Transition Team Proposal' (Exhibit 2) and 'Summary of Learning from Unsuccessful Trial Placements' (Exhibit 3) identified the challenges and made proposals, noting the Transition Team Proposal was well below what would have been comparable to work that was well evidenced in mental health services (described in the final section of exhibit 2). As Service Improvement Manager and a social worker, my professional opinion was that a resettlement team model would improve the quality, safety and effectiveness of discharge arrangements and make a difference to the patient's experience of the transition from long stay hospital to community placements through more intensive co-production, planning and post discharge support. There was co-production, I just believed we could do much more and better work if there were resources and that those involved were doing what they could at the time.

40. Concerns about the development of a resettlement or transition team were raised by community staff on the basis that it could deplete their workforce and this impacted the support for further development of a resettlement team.

41. The work on Barriers to Resettlement and the Transition Team Proposal led to the Belfast Trust introducing two additional staff to support resettlement, namely a second Community Integration Post in December 2019 and a social worker in 2020. The two Community Integration posts were divided with one post to support the Belfast Trust and the other to continue supporting the other Trusts. The additional staff enabled the assessment forms to be redeveloped with the learning from SEAs, detailed Essential Lifestyle Planning (ELP) work to begin on a number of proposed discharges and increased work with the wards and post discharge support to providers. It was intended that the team should have been developed further as detailed work takes time, though would not have needed to be to the same scale as the mental health resettlement team as in-patient numbers were reduced.

42. The South Eastern Trust had dedicated ELP staff, which resulted in a robust process and co-production, this model had been in place for a number of years which meant relationships had been built with patients and their families (see Exhibit 2 page 8).

ii. How closely were the staff who were responsible for the day to day care of patients at MAH involved in the resettlement process?

43. The staff responsible for the day to day care of patients were involved in the resettlement process. Parts of this have already been described as ward staff supported in-reach and provided out-reach work.

44. Resettlement work took place at ward level with multi-disciplinary discussions, planning, family and carers invited. The level or depth of this engagement would have been significantly increased with person centred planning and increased resources.

45. Improved communication between ward staff and resettlement staff was an issue raised by ward staff, and in order to improve communication and on discussion with the Divisional Nurse, a representative from the resettlement staff joined part of the Ward Managers' meeting to share information, provide updates and give an opportunity to raise questions.

iii. What training was provided to BHSCT staff on the resettlement process and best practice in that regard?

46. Information and discussion on resettlement was brought to the Ward Managers' meetings and during the time I spent at MAH I had regular discussions with ward and community staff on both their learning and the learning from the resettlement experience in mental health services.

47. Belfast Trust linked with the East London Foundation Trust (ELFT). There was on-going communication with ELFT and visits were made by groups of community staff to learn from the services in England. ELFT used an intensive community support model to meet needs of service users in the community. Information from the experience was shared across services in Belfast Trust.

48. The purpose of completing the review of SEAs (Exhibit 3) was to use it for training and development with hospital, community and potentially independent sector staff (Exhibit 3 page 4). Learning had already been used to improve the assessment forms. The SEA learning provided recent practice examples of the detail required, suggestions for what should be assessed and how placements that breakdown are often described as a singular event, whereas it was often a series of issues, some of which might not seem important but are exceptionally important to the service user.

49. Both Community Integration post holders were highly experienced in complex discharges and provided that experience at ward, community level and were able to develop the new social worker's skills.

iv. How were patients' requirements assessed and how were patients matched to resettlement placements? The Inquiry has heard of inappropriate placements for resettlement, where patients' abilities were significantly overestimated. How did that occur?

50. Resettling patients, who have spent years in hospital requires (a) the knowledge from ward staff who understand the patient in a ward setting, to include any adaptations to support and minimise behaviours, and off ward activities, (b) family and carers providing their perspective and detailed knowledge from before and during the in-patient admission along with personal information that may not be as well-known or experienced by ward staff (c) community staff have knowledge and expertise of what services can be provided, what has worked well and can be expected in the community (d) the person's perspective, their individual likes, dislikes and what is important to them (e) a knowledge of the person's history and any previous placements including what worked well and where things need to improve.

51. The SEAs provided learning on how missing information or assessing as a general discharge at the stage of resettlement was becoming problematic (Exhibit 3). Exhibit 3 page 2 outlines that of the 25 discharges in 2019-2020, 19 were successfully placed and 6 patients returned to the hospital. An SEA process was in place for unsuccessful discharges, and I undertook a review of the themes and practice examples from the SEAs. Exhibit 3 page 4 outlines the use of the learning from the review of SEAs both within the Trust and with external providers.

52. The exhibits provide an explanation of the challenges and limits to resettlement in 2019/20, including acknowledging that placements were named for patients and some of these may not have been appropriate.

53. The community is a very different environment to a hospital and an assessment of an individual's potential response to the degree of change involved and the dynamic with other service users can be a complex process.

54. On reviewing information and from the learning gleaned from unsuccessful placements, where assessments had been completed, it was apparent these assessments were generally not robust or detailed enough and had on occasions, missed vital information.

v. What consideration was given to the skills and competencies required of care workers who would be supporting patients with complex needs following their discharge from MAH?

vi. What, if any, training and/or resources were provided by BHSCT to independent providers and/or care workers who would be supporting patients with complex needs following their discharge?

55. The skills, competencies, recruitment, retention, terms and conditions of the social care workforce were routinely discussed and raised as challenges. It was escalated at MDAG through the presentation on 'Homes not Hospitals' (Exhibit 4), specifically slide 12.

56. Agreements were in place that meant independent provider staff were able to come onto the ward, often in a phased way, and start to build a relationship with the person and to understand their routines, personality and needs as part of the discharge / transition process. There was evidence that the quality of the in-reach work varied and following the learning from the SEAs, resettlement staff worked with ward staff to ensure in-reach / outreach work was monitored and that check lists were used to ensure particular care tasks and experiences had been trialled,

such as visits off ward and off the Muckamore site. There had previously been guidance for staff and this was re-issued.

57. Psychology staff were also involved in supporting transition work and the use of Positive Behaviour Support (PBS). Pressures on resources and staffing also affected what was possible. Part of the improvement work was to increase psychology input at the assessment stage.

58. PBS and higher costs for staff training and supervision were discussed and included in costings for some of the supported housing schemes. There was a variation between schemes and providers in terms of what could be offered. Some providers began to introduce higher level skills such as the PBS model. Full implementation of PBS can range from an entry level of PBS awareness for staff to more comprehensive training with psychology led supervision of staff and PBS plans.

vii. What efforts did BHSCT make to ensure staff at MAH fully co-operated with visiting staff from other sectors involved in resettlement? Was BHSCT aware of any problems with the co-operation of MAH staff with visiting staff from other sectors?

59. My knowledge of this is limited to the timeframe I was in post as Senior Improvement Lead. I recall issues being raised by ward staff about staff from a provider not arriving as planned or where the provider was not taking a person out as expected or planned. The process was that issues with or raised by a provider would have been logged as a Datix incident with follow up by Community Care Management as commissioners or Nurse Leads in the hospital, depending upon the nature of the incident. These experiences were similar to what I had seen in mental health resettlement, during which the resettlement team would have managed the interface between providers and the hospital.

viii. The Inquiry notes that, in addressing Module 3(h) of the Evidence Modules: March-May 2023, BHSCT provided a document entitled "Belfast Trust Resettlement Process Document MAH 2021". For the assistance of the Panel, please exhibit a copy of that document to your statement. Please also explain what process existed before May 2021 and how was it communicated to MAH staff?

60. As I worked in Learning Disability services between 2019-2020 I was not involved in the document (dated 2021) and am unable to comment on it.

3. If a resettlement of a patient from MAH into the community failed:

i. What analysis was typically undertaken to understand the reasons for the failure?

ii. What learning was identified in respect of failed resettlements and how was any learning recorded and shared to improve future resettlements?

iii. Please note that BHSCT has already provided the Inquiry with a document, authored by you, entitled "Summary of learning from unsuccessful trial placements" which is dated June 2020. For the assistance of the Panel, please exhibit a copy of that document to your statement. Please also explain what process was in place prior to June 2020 to analyse and learn from unsuccessful resettlements?

61. The Significant Event Audit (SEA) process was in place for each unsuccessful placement while I was at MAH and this was supported by the Governance Lead. A summary of those involved in SEAs is in Exhibit 3. I am unable to comment or provide information outside that timeframe.

62. As Senior Improvement Lead I had attended the SEA meetings for the individual cases. I raised with Marie Heaney, Director, the suggestion of bringing the learning from the recent SEAs together into one document in order to analyse themes and develop information that could be shared as both learning for staff and to improve assessments. While the review was completed in June 2020, some of the learning was already being applied through changes to assessment forms and the proposal to further develop a Transition Team (see Exhibit 2). In the Summary of Learning document the core themes identified that led to placement breakdown involved deficits in communication, assessment, care plan including PBS and discharge planning, workforce and provider or new environment unable or unsuitable to meet the needs. The review identified Key Learning & Recommendations. On leaving my post I ensured the document was shared and I recommended that it be used for further learning (with anonymisation).

4. What targets or guidelines were given as to the rate of resettlement of patients from MAH, throughout the time period covered by the Inquiry's Terms of Reference. In answering this question, please explain:

i. Who set those targets?

ii. What input did BHSCT have into setting targets for resettlement of patients from the hospital?

iii. What effect did targets have on the quality of placements available for patients resettled from MAH?

iv. Did failures in resettlement increase as pressure to meet resettlement targets grew?

63. Due to the relatively short period I was Senior Improvement Lead in Learning Disability I am unable to answer these questions in detail and can only answer in relation to the period of time I looked at in my role.

64. In 2019 the intention to resettle the patients in MAH and close the hospital by December 2019 was announced by the Department of Health. I accepted that while safeguarding was a major driver, my experience of mental health resettlement led me to believe this was neither achievable, person-centred or safe.

65. I cannot recollect a specific target other than the full resettlement, however, there was likely to have been an annual performance metric. My primary concerns in 2019/20 were in relation to the assessments, proposed placements and how the drive for discharge may be impacting the quality, safety and effectiveness of placements. There were regular meetings with the HSCB on discharge performance and in 2019/20 the challenges and problems with the process were being shared at these meetings and MDAG.

66. As a Social Worker with professional values and experience in resettlement, this was sometimes a difficult position which involved sharing challenging information. However, unsuccessful placements are very real and potentially traumatic for the patient, family, carers and also for some of the staff involved so my role was balancing that people should not be in hospital for longer than needed alongside ensuring effective and safe discharges.

5. Was there a lack of suitable placements for resettlement of patients from MAH? If so, please explain:

i. When this was an issue within the time period of the Inquiry's Terms of Reference.

ii. What engagement did BHSCT have with other stakeholders in the resettlement process to discuss the lack of suitable resettlement places available? How effective was any such engagement?

67. Placements were an issue throughout the time I was in post. As previously referenced, the reasons were multi-factorial.

68. The independent sector providers remained under the responsibility of care management / commissioned services and the Service Manager for Community Services and Resettlement (for Belfast Trust patients). I did not have the complete picture on what was available, although by having an oversight of the plans I was able to identify where resettlement plans were proposals, as opposed to actual discharge plans, and that a number of these proposals were unlikely to be achieved.

69. In mental health services a scoping exercise of placements and future need had been completed, I am unsure if that had been completed in learning disability services in 2019/20 and I am unable to comment on the longer-term communication with stakeholders.

6. Please explain whether BHSCT considers that funding for the resettlement of patients from MAH was adequate throughout the time period within the Inquiry's Terms of Reference?

In answering this question, please explain whether funding for resettlement adequately responded to government policy to increase the number of patients resettled out of MAH?

70. I would not be in a position to comment on behalf of the Belfast Trust on the funding for Learning Disability Services. As a Senior Improvement Lead I had no budget responsibility.

7. What impact, if any, did the government policy to increase the number of patients resettled from MAH into the community have on the effectiveness of resettlement of patients from MAH?

71. A policy to end a model of institutional care and Bamford's vision for people living in the community are undoubtedly the right thing to do. The setting of unrealistic timeframes (December 2019) for the full discharge of long stay hospital patients potentially impacted decision-making. I found that I needed to give staff safety to flag where there were concerns and encouraged an open culture. There were multiple reasons impacting the effectiveness of the resettlement process as outlined in the exhibits to my statement.

8. What were the main challenges in the resettlement process of patients from MAH, throughout the time period within the Inquiry's Terms of Reference, that is 02 December 1999 to 14 June 2021?

How did BHSCT engage with other stakeholders in the resettlement process to discuss any such challenges and seek to improve the process?

72. I refer to my previous answers in relation to the challenges in the resettlement process and to the Exhibits to my statement.

73. Regular meetings were held with providers, staff, Trusts, the HSCB, Department of Health, family and carers and service user groups. I would have been involved in a number of meetings, the majority of which were managed through the Community Services Care Management. By February 2020 the challenges had been shared with MDAG.

9. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of paragraph 16 of the Terms of Reference?

74. I wish to inform the Panel that the vast majority of learning disability staff that I encountered during the nine months I was in post were dedicated, passionate and understood the needs of people with a learning disability. A number were exemplary.

75. On moving to work in MAH, I observed a marked difference between resettlement within learning disability from what I had seen had been developed in mental health services. The mental health resettlement team comprised of a lead Consultant Psychiatrist, a Team Lead, three social workers, three community psychiatric nurses, one occupational therapist, a care manager, three-four support workers, an independent advocate. The team intensively worked with in-patients through assessments, care planning, risk assessment and for one-two years post discharge, after which cases could be transferred to community teams. The service wrapped around the service user, their family, carers, ensured co-production and gave on-going support to the providers. It also gave a single point of contact and management structure to ensure a cohesive, seamless service and effective communication with families, service users and providers.

76. Supported Housing and commissioned services was also within the line management structure of the service and a Community Plan was developed based on a scoping of the available accommodation alongside the projected needs of the population. Information was presented, discussed and agreed at management level within the service and decisions made which enabled plans to progress. Business support and co-ordination of Supported Housing was through Maurice O'Kane and we met with the HSCB as part of the Belfast Area Supporting People Partnership (BASPP), which ended after NIHE Supporting People funding became limited. Funding was primarily through the PTL HSCB for placements. The service resettled 100+ long stay patients, including a number of highly complex individuals and closed 3 wards one of which was a regional brain injury unit. There was a less than 2% readmission rate and these readmissions returned to the community once their health stabilised as the admissions were not related to placement breakdowns.

77. As the in-patient population was discharged, the skills and expertise developed by the team was captured through a change process to become a community rehabilitation service to provide an intensive support team to service users, families and carers, reduce the need for hospital admission and reduced the impact on community teams.

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: Fiona Rowan

Date: 12 June 24

Exhibit Bundle – Statement of Fiona Rowan

Exhibit Number	List of Exhibits	PAGE
1	Proposals to Address the Barriers to Resettlement of MAH patients, MDAG	1-9
2	Transition Team Proposal - February 2020	10-18
3	Summary of Learning from Unsuccessful Trial Placements for Regional Intellectual Disability Discharges - June 2020	19-55
4	Homes Not Hospitals PowerPoint – An Analysis of barriers and learning to support people with a learning disability and/or autism who display behaviours that challenge including those with a mental health condition	56-76

Proposals to Address the Barriers to Resettlement of MAH patients to be tabled for consideration by MDAG v5

Context

There is a range of complexity in the needs of MAH patients, from those with less complex needs to those with complex needs and behaviours to the most complex patients. Those patients with the most complex needs are generally those that remain in MAH or have returned to MAH after an unsuccessful placement. There are currently 56 patients in MAH. There are 6+ different non-statutory providers currently involved in the resettlement plans for these patients and MAH patients have been resettled in many different facilities across the Belfast, Northern and South Eastern Trusts. This highly complex group of individuals, the diversity of support organisations providing care for them and the geographical spread of community accommodation raises some important issues for regional attention if we are going to be able to sustain these placements and deliver on our commitment to an improved life experience for these individuals.

In setting out the context, it should be acknowledged that the staff are risk managing incidents that can be physical, aggressive, and repetitive and, in some instances, sexual in nature. It is apparent that while much work has been undertaken on Positive Behaviour Support and improving environments, staff working in this sector have been regularly injured both physically and emotionally while providing care, yet remain some of the lowest paid. Being unable to safely manage behaviours and incidences in a community setting can be one of the primary causes of re-admission and an unsuccessful placement. There are multiple factors behind each example, which includes low grade / paid staff, inexperienced staff, transient workforce, robustness of care planning, dynamics between residents, numbers of people with higher complex needs in one setting and managing in a new setting for both staff and residents. The majority of recent unsuccessful placements have arisen following incidents, with staff subsequently leaving or threatening to leave post and some move to another provider, a knock on effect that can de-stabilise a service.

This paper proposes that the right assessment, discharge plan and right provider are key to a successful resettlement. There are other important considerations eg the statutory sector should consider its role to be able to provide statutory accommodation based services for the most complex people in supported housing (ie a mix of Band 5 staff, including professional & non-professional staff, including social work, nursing, AHP staff). This would be as part of a mixed economy alongside C&V private sector organisations eg a provider is developing specialist LD nursing care in a community setting. The scale of resource required is significant and highlights the need for a multi-disciplinary workforce planning strategy for Learning Disability. Examples: one of the C&V services requires 80 support workers to support a 12 person

development (excluding supervisory staff) and at another facility, each individual requires 4.5 WTE Band 4 staff, excluding supervisory and managerial roles.

The Trust is therefore proposing to replicate the resettlement model used in other services (eg mental health) which would address these considerations and improve the robustness, quality of the discharge process and outcomes for providers, patients and their families. The resettlement model, in isolation, is unable to resolve all the staffing, timeframe and infrastructure issues outlined in Table 1.

Table 1: Outline of Barriers to Resettlement and BHSCT Proposals

Barrier: Statutory Community Infrastructure	**Proposals**
• There is a very limited community service to provide either an intensive wraparound support or the flexibility to respond to prevent and manage crisis situations in the community. Currently Community Teams provide a 9-5 Monday to Friday service • The numbers of people being supported in the community alongside the population awaiting to be discharged, are increasingly complex, adding pressure to Teams and increasing the likelihood of unsuccessful placements / admission to hospital in the future • Current Community model does not provide accommodation based services in a community setting for complex behavioural needs that are at the most challenging to services, this is currently commissioned out to C&V leaving statutory services heavily reliant on C&V provision.	• Consider the development of a wrap around Intensive Community Support Service or an extension of existing community Teams to maintain people in the community both in and out of hours, to reduce / minimise the need for hospital admission • *Sarah – please feel free to rewrite and add to this* Development of Positive Behavioural Support services (PBS) in the community is required to support staff and new accommodation based services to meet the needs of people already being discharged and into the future. MAH holds the most experienced and skilled PBS staff that can provide a learning opportunity for the development PBS practitioners. • Statutory Community model / services need to target and be able to meet the most complex needs. Development of 6 bed, high level statutory Supported Accommodation (Supported Housing) for people with behaviours that challenge services –

• Overnight respite provision is limited and there is no provision for people with more complex needs in the community. This is an unmet need that is essential to support families and carers to continue caring for family members at home.	this would be at the highest level of need managed in the community • A specialist LD Nursing Care provider is planned (but not yet funded) to include 2 respite placements, this will be at high cost and a limited service (BHSCT only)
Barrier: Non-statutory Community Infrastructure	**Proposals**
• Community requires a stepped model of care ranging from Supported Housing to Learning Disability Nursing care • Providers capacity to manage the most complex cases • Number of people with complex and challenging needs in any one setting can lead to a dynamic in the scheme • Rapid expansion in the Non-statutory provision, driven by resettlement has resulted in an instability in an already fragile and limited market (see under staffing resources)	• Development of specialist LD Nursing Care in the community that can meet the needs of patients who have behaviours that services find the most challenging to manage (potential to develop with All Ireland Healthcare) • Development of small scale Supported Housing Schemes, maximum 6-10 places • Partnership working with C&V and private providers to increase their capacity to manage through support, training and wraparound services • Recognition and support by Commissioner that funding needs to be made available for these revised service delivery requirements.

<table>
<tr><th>Barrier: Learning from Unsuccessful Placements</th><th>Proposals</th></tr>
<tr><td>

- In November and December 2019, BHSCT reviewed a number of the unsuccessful placements and there were 3 key common areas for improvement:

  1. Assessments and Planning
  2. Care Plans
  3. Communication between Hospital, Community, Trusts, Carers and Providers

- Assessments are not sufficiently comprehensive to ensure robust discharge plans

- Discharge Planning requires improvement and benchmarking against best practice, with increased involvement with families and carers

- The use of Essential Lifestyle Plans (ELP) has been underdeveloped and can be dependent upon Trust

- Communication with Carers on resettlement plans is insufficient or non-existent and is raised regularly as a failing for MAH and Trusts

- It is now recognised that the BHSCT Community Service do not have the resources to allocate the staff or the time required to work more intensively with the remaining patients at MAH. This position is due to funding, vacancies and service pressures.

</td><td>

A Resettlement Support Team is being proposed to enable the intensive assessment and discharge planning required between Hospital and Community. Details of Team would require:

The Team would have the capacity to work with all Trusts to ensure the following are in place for each patient

- Essential Lifestyle Plans
- Detailed Care Plans
- Carers Needs Assessments
- Comprehensive Discharge Planning Process
- Mental Capacity Act assessments
- Declaratory Order completion
- Structured and detailed management of in-reach and out-reach working with providers
- Manage PBS Support
- Comprehensive information shared with providers

Families and Carers need to be supported to be involved throughout the discharge planning and that their knowledge of their family member is both central and should be clearly evident through ELP and Discharge Planning.

The implementation of a Resettlement Support Team should be progressed which will coordinate and take responsibility for the successful placement of each patient. This approach has been evidenced as both successful in managing complex resettlements through the BHSCT Mental Health Resettlement. It places families and carers at the core of their work.

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</table>

• The current BHSCT resettlement model relies on 1WTE to co-ordinate discharges, this is an insufficient resource to complete the detailed work required • Ward staff are a limited resource and need to focus on managing ward based issues	Risk to be flagged: that developing a resettlement model will negatively impact staff resources elsewhere. A detailed review of the position on assessments, ELP, Carers Assessments and any legal processes required, is planned for January 2020. Communication Strategy for staff, families and patients has been developed for the Mallusk resettlement and this will need to spread across all resettlements Feedback from Carers is being responded to, initially through 'Resettlement Clinics' being offered to carers across December and January, with a view to extending further in the New Year
Barrier: Timeframes required to develop new Community Services	**Proposals**
• The original proposed timeframes were an underestimation of the challenges involved in a large scale resettlement of patients with highly complex needs • Timeframe required for new Supported Housing schemes is usually around 3 years from SOC to OBC Planning, build and phased occupation. • The services could not have foreseen the difficulties in recruiting and retaining the staffing resources required. • Collapse of Regional Supported Housing Plan in November 2016 led to no new developments	• Many of the patients remaining in MAH require a bespoke environment and that this environment is as critical to meeting their needs successfully in the community as staff care. • Strategic Outline Cases have been developed and BHSCT are actively completing Full Business Cases. • Ongoing partnership work between NIHE/DoH & DfC is needed to sustain resettlement timeframes.

Barrier: Staffing Resources across LD Services (Hospital, Community, C&V)	Proposals
• There are insufficient staff available to meet the current and future demands on the LD sector across both statutory and non-statutory services, for eg: • Outreach work adding to the pressure on Muckamore nursing and care staff, which could be expected to escalate significantly during the opening of new schemes next year • Community Statutory LD Teams have significant vacancies and therefore limited resources • Statutory Accommodation based services experiencing exceptional recruitment and retention difficulties • The opening of a new development in the C&V sector is de-stabilising the current provider as staff shift from one provider to the next • Pay: particularly relevant to C&V Supported Housing Sector, where the core staff (Support Worker) salaries are commensurate to a Band 2 grade, resulting in a low paid and unstable workforce • Staff movement in C&V leading to the loss of consistency of staff which for many patients is critical to their community success. • Instability in the workforce has wider consequences on organisational performance including time diverted into repeated recruitment drives, training and development,	• A Learning Disability workforce planning strategy is required. • A regional approach to LD recruitment across all professions and support staff is required following the Muckamore review and its impact on staff morale and retention. • Trusts are working in partnership to meet with providers to address capacity • Contracts with providers will be reviewed to make expectations clearer • HR support to manage recruitment challenges • Regional forum and agreement to consider low paid working in this sector

agency staff resulting in higher costs without an improvement in the service. • Recruitment for LD services has been effected by media coverage, in particular staffing for MAH and services in the close vicinity	
Barrier: Location of New Community Accommodation Based Services	**Proposals**
• New Accommodation based developments for a specific group of existing patients (approximately 8 patients) in a Trust area significantly increases the pressure and demand on the Community Service, there is an understandable reluctance for further development within each Trust area, • Patients in placements receiving services from a host Trust, again creates a pressure on other areas and who holds the responsibility for out of hours care needs • BHSCT has taken the lead on the submission of Business Cases	• A Regional forum for the agreement on the siting of new services • Agreement on the Regional Protocol for out of area placements and host Trust responsibilities

Barrier: Medical Cover Community and Hospital	Proposals
• Joanna – think you will want to add the specifics on Consultant cover	

Conclusion:

Current community services and provision, both statutory and non-statutory, are under strain or are too under-developed to safely meet the complex needs of the MAH patients involved in this final stage of resettlement. Providers have limited experience of meeting the needs of some of the current group of in-patients and services are entering a new level of community commissioning and provision. Such changes must be taken at a steady and well-managed pace and pushing the capabilities of these developing services without a statutory community infrastructure in place will ultimately lead to further instability and a negative community experience for patients and their families. It is of concern that a number of patients and families have already had this experience and it is understandable why some families continue to see in-patient provision as a better option, despite the background of adult safeguarding. We need to learn from the unsuccessful placements and establish the appropriate supports and systems to ensure an improved life experience for these individuals in our care.

Next Steps:

1. Regional agreement is required on the need to build a sustainable workforce across both statutory and non-statutory sectors to meet the current and future needs of resettled LD patients or patients with this level of need. A number of recommendations for development should be considered:
   -skill sets of staff working within community settings;
   -wraparound and ongoing support team within each Trust base;
   -approval to proceed with business case development by NIHE to meet patient needs within Trusts;
   -statutory management for the most complex patients;

-discussion on the appropriateness of a resettlement support team
-further provider support, review and challenge.

2. Ongoing strategic working with the NIHE and RLDODG
3. Further development of our Provider contract relationships with the C&V sector to ensure agreement on priorities, current and future funding commitments and review on delivery against existing schemes.

Fiona Rowan

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Transition Team Proposal, February 2020

Proposal

The Community Integration posts that are currently in place, provide an oversight over the 53 patients resident at MAH. What is now proposed is to have 2 dedicated staff, at community keyworker level to provide consistency, develop skills, actioning the learning from failed placements and be able to provide a high intensity, low volume service to BHSCT patients, families and providers. Belfast Trust currently has 20 Patients remaining in MAH, meaning a caseload of 10 per keyworker, which would be comparable to the SET keyworker model

It is recognised that any proposal has consequences on other parts of the service. As the work required would already have a significant impact on the workload of the Community LD Team the redeployment of one staff member has been discussed with the Head of Community Services. A second staff member, potentially Agency is proposed.

The proposal of 2 staff is a minimum staffing level. A well-developed, robust team would include a Team Lead, OT, Psychology and could potentially be used as a service for any complex discharges leaving Assessment and Treatment at a more timely rate than the previous hospital discharges. The experience staff develop in this type of working would also enable them to work effectively in transition work for young people moving into adult services, as demonstrated by the ELFT team.

Care Management in-put – has been discussed with ASM for Care Management, it was agreed that 2 Care Managers would be identified for Bradley. This is based on previous experience, where multiple Care Managers are no longer the preferred option as it can lead to information being diluted. Staff are able to monitor the service more effectively, increases consistency and is better for communication. Some consideration should be given to these individuals to limit other parts of their caseload where possible.

The proposal is for BHSCT only and has therefore not included consideration of other Trusts, (both Ann and Kim's roles extend into a co-ordinating role for all Trusts); a summary of their in-put is included.

Staffing Proposal	
Managers (includes regional work)	2 Community Integration staff (in post, no admin attached)
Keyworkers	2 WTE (1 Internal, 1 Agency)
Admin	To be discussed

Failed Placements and Learning

A review of the failed placements through the SEA process has been completed on the 5 SEAs from 2019 (TJ, FA, GM, JG, DMcM). While individual pieces of learning have been identified in each, there are common themes emerging

- Communication
- Care Planning and adherence to care and PBS Plans
- Expectations of Provider and LD Services
- Community infrastructure
- Workforce, Trust and C&V, Hospital & Community

Communication

A key feature in each SEA has been effective communication, this is evidenced as a critical risk area at all stages in the placement, from the management of in-reach and out-reach activities through to medication and information sharing. The complexity and potential for error and diminished quality needs to be high-lighted. The communication of information between families, carers, ward staff, providers and Community Services is highly complex and requires consistency and an understanding of providers and community working. The more factors and individuals involved can impact the communication and therefore outcomes for all involved. A small but significant identified problem has also been around the routine practice of delegation of tasks and the gaps in

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communication that has been evident, during which decisions are made and shared with staff who are not present, this has led to miscommunication, often with no identified person responsible for following up.

Improvement Example: A senior member of the Community Integration staff to lead on each case with a dedicated keyworker from the community for the transition work. There is clear responsibility and a lead for all communication with one consistent keyworker who knows the patient, their needs and family in comprehensive detail.

Improvement Example: A weekly meeting managed by community staff initially on the ward, throughout all in and out reach activities, adherence to and use of the In-reach, Outreach Guidelines. This enables the monitoring at ward level of provider compliance, shadowing opportunities, effectiveness of the activity, building the relationships and early alerts where potential problems arise or if the activity is not following the agreed pathway, so it can be reviewed and improved.

Use of Community Teams in Complex Resettlement / Discharges

This works best when the community staff are familiar with the patient, however with changing staff, Community Team having difficulty with recruitment, capacity combined with the length of stay of patients means this is less likely. Managing the complexity of transition work benefits from a dedicated keyworker with the capacity and caseload to permit developing a relationship with the patient and family, several months prior to discharge to enable them to be an effective support to community, ward staff and providers. Knowing the patients well and having the caseload to allow daily monitoring also allows the staff member to recognise and resolve potential problems much earlier, including raised by families or providers. Examples from the SEAs include:

- Wifi not working,
- a TV being broken,
- family members not feeling listened to by providers,
- provider staff not confident or experienced in taking a service user out, resulting in person not going out
- dynamics between residents that occurs in a different setting, which wasn't able to be fully understood on the ward
- supporting an understanding of behaviours, when they are experienced as opposed to read in the care plan
- that SEAs are identifying limited or failure to adhere to Care Plans and PBS plans

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Weekly contact by staff who are not as familiar with the patient, once ward staff start to withdraw, potentially reduces the likelihood of a good outcome as they can be equally unfamiliar with the person, how to support them and to closely monitor adherence to the PBS and Care Plans.

Community keyworkers will have limited knowledge of the failed placements, so learning is limited to reviewing the SEAs rather than the active learning. To have different keyworkers on each case reduces the learning, consistency and are constantly subject to the pressures of caseloads in the community and therefore effective communication.

A summary of successful and failed placements is attached (4/2/20).

Benefits of High Intensity Low Volume Work

Intensive working with a lower caseload is the accepted and understood practice that has been the foundation of developing many Teams managing complex needs throughout Northern Ireland and UK eg Early Intervention Teams, Transition Team in ELFT, Forensic Teams. These teams are also characterised by staff being well supported and therefore staff consistency is a feature, also reflected in the resettlement teams for the other Trusts.

Team	Average Caseload Per Keyworker
Community LD BHSCT	40-60
Community MH BHSCT	50-60
SET & BHSCT Community Forensic Service	10-13
East London FT	20 (for a well developed, established service for young people moving from Childrens Services rather than hospital)
Early Intervention Team BHSCT	14-18

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As with the SEA learning with providers, staff consistency is as vital with Trust staff in supporting people resettle from long term hospital. The preferred option is that keyworkers start at an early stage and would remain with the patients through discharge and until the placement is completely stable. This extends well past formal discharge and should be anticipated to be up to 1-2 years before the person could be transferred to the lower level of working provided by the Community LD Teams. New developments and services are also known to take this length of time to be stable and have developed the required workforce, skills and experience. Therefore staff managing new service developments have the additional risk of a new service, a new environment with potentially less experienced staff, where the ability to manage behaviours and complexity is untested in that setting.

Generic Teams are designed to manage higher caseloads and are placed under pressure when demands due to crisis situations arise. High intensity, low volume work is about effective management to prevent escalation, while having the lower caseload allows the service to flex during periods where intensity can increase and the service needs to respond.

Completion of Assessments, Needs Assessment, Care Planning, Person Centred Planning, Hospital Passports

A comparison of each Trust's dedicated resources to resettlement is provided in the appendix. In summary, NT and SET both follow a Resettlement Team model with dedicated resources of Key worker / Social Worker, using the high intensity low volume model, with limited caseloads.

Whereas, Belfast Trust patients are referred to generic Community LD Teams and assigned a Care Manager. These Community Teams are already experiencing difficulty in meeting current community demands. With some teams entirely reliant on agency staff. Caseloads are already high and therefore have no capacity to monitor and work with providers in the intensive way that the other Trusts can provide or to manage the most complex patients who require discharge planning.

The Head of Service has confirmed that Community Teams do not have the capacity to provide PCPs/ ELPs and would be unable to offer the high intensity low volume working proposed. Assessments and Care Plans have not been completed for Bradley Court. The next year will require intensive working to support patients move to Bradley Court and Mallusk.

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A number of case examples are being summarised that are being worked with increased intensity, this is only possible as there are lower discharges at present and without the opportunity to redo assessments. Contingency planning, compatability work, managing in –reach and out-reach more effectively, leading in partnership with the MDT and intensively working with service users, the ward staff and providers requires time and an understanding of the difference between hospital and community living and services.

Timeframe

The timescales to have the required work and the relationships developed before the opening of Bradley Court and Mallusk in the summer are approaching a critical stage, the type of preparatory work becomes less achievable the closer to discharge. The failed placements and current discharges continue to be based on the original method of proposing a patient for a placement and then completing the assessments and care planning, these proposed placements are therefore not using the standard process of assessment leading to decision making. This is due to the current model of using a generic community team to meet highly complex needs. The proposed plan would be to return the patient journey to the usual pathway, which is that the assessments and care planning are key to any further decision making.

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Failure Rate of Resettlement – 2019/20 Year To Date

The table below shows the failure rate of resettlement from 1st April 2019 to date. This has been calculated by excluding the patients who are currently in trial resettlement. For example, the BHSCT failure rate has been calculated using a denominator of 8 completed resettlements, of which 2 have failed.

It is important that these figures are updated regularly and shared across Trusts and in the Department of Health to ensure consistency of message. The regional position is a 36% failure rate.

	2019/20 Year To Date			
	Successful Resettlement - patient discharged	**Failed Resettlement** - patient returned to MAH	**Ongoing Resettlement**	**Failure Rate**
BHSCT	6	2	3	**25%**
NHSCT	6	3	0	**33%**
SEHSCT	1	0	1	**0%**
WHSCT	1	0	0	**0%**
Total	**14**	**5**	**4**	**36%**

Please note this is updated weekly, information live as of 10/2/20. P254s was not included as that was pre April 2019. Next week the table will show P255 as discharged.

Summary of Resettlement Team Staff by Trust

South Eastern Trust	**Number of Patients:**
Social Work (Resettlement Keyworker)	Susan Shepherd – staff member dedicated to resettlement, years of experience in resettlement (caseload of 10, including 2 discharges)
Essential Lifestyle Planning	Dedicated Trust ELP worker
ASM Lead over ISS and Resettlement	Roisin O'Hare

Northern Trust	**Number of Patients:**
Band 7 Resettlement Lead	Teresita Dorman – provides a lead role to Resettlement Team; Social Work and OT
OT	Una Cassidy Band 6 OT – dedicated OT to Resettlement Team
Social Work	Alicia Doyle - dedicated staff member to resettlement Alex Walker – specifically for DoLs (part-time)

Belfast Trust	**Number of Patients: Responsible to co-ordinate 53**
Community Integration Workers	A hospital focussed co-ordination role, which has an oversight with multiple roles, coordinating meetings, supporting and liaising with other Trusts involving reports, HSCB returns. 1 post had oversight of 50+ patients, the scale of the post and ward meetings limits the direct involvement in each case.

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	Post is impacted by all Trusts – so no dedicated resource for BHSCT *Additional staff member recruited to develop the service and increase time spent with individual cases, 25+
Keyworkers	No dedicated Resettlement Resource for BHSCT community patients, no ELP in-put Limited availability: taken from generic Teams, experience dependent upon the individual Impacted by community pressures and large caseloads

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2020

Summary of Learning from Unsuccessful Trial Placements

A SUMMARY OF THE LEARNING FROM UNSUCCESSFUL TRIAL PLACEMENTS FOR REGIONAL INTELLECTUAL DISABILITY DISCHARGES.

ROWAN, FIONA

BELFAST H&SC TRUST | June 2020

Contents:

Background and Review of SEAs, 2019 - 2020

Part 1

Key Learning

Red Flags

Part 2

Examples Section

Background and Review of SEAs 2019-2020

During the period of February 2019 – February 2020, there was a total of 25 patients with planned resettlements, of the 25, 19 were successfully placed, with 6 placements that were unsuccessful (3 Belfast Trust and 3 Northern Trust). Each unsuccessful placement was followed by a review, using the format of either a Shared Learning Event or a Significant Event Audit. The type of learning event was dependent upon the Trust involved, all resettlements were patients from Muckamore Abbey Hospital.

Each SEA invited / involved representatives from the following groups;

- MAH Multi-disciplinary Team; including Consultant Psychiatrist, Nursing, PBS, OT, Community and Resettlement staff,
- Carers advocate
- Independent Sector Provider (ISP)
- Family or carers were invited to attend, or if choosing not to attend were given the opportunity to share their view of the placement
- Trust involved (NT or BT)
- During later SEAs a representative from the HSCB was also invited, with consent from families

The main purpose of the summary is to draw out the key learning so that it can be used to improve assessment, discharge planning and therefore an earlier detection and opportunity to address or avoid pursuing unsuitable placements, and reduce placement failures. The review can also be shared as an alert to staff as to what may be early signals of a potentially failing placement, i.e. ‘red flags’ that require immediate action.

Part 1 of the report summarises the learning from each of the SEAs. Which is information that could be openly shared. Part 2, the ‘Examples Section’ provides concrete examples of the day-to day issues that arose during leave on trials. These examples are to demonstrate what the themes look like in practice and are therefore more recognisable in practice than the use of generic themes.

Due to the highly specific nature of some of the ‘Examples Section’, Independent Sector Providers (ISPs) may be able to identify service users, which would require further anonymisation. The learning is as relevant to ISPs as it is to HSCTs and it is intended that the summary could be used by BHSCT ID Resettlement Teams to develop a learning opportunity to share with the new providers, their managers, staff and as part of learning for new developments.

The document will be used by BHSCT as a reference to improve the assessment process. It high-lights the value of co-ordinating and ensuring an approach that pays attention to detail and that it is the attention to detail that can have the most impact on the quality of life and discharge experience for the patient, their family and the staff involved.

BHSCT ID Resettlement Team is using the document and learning to develop assessment checklists as part of an Intensive Discharge Planning Process which is being co-produced with carers. The key themes that have led to placement breakdown during leave on trials regularly involve deficits in the following areas:

- Communication
- Assessment

- Care Plan and discharge planning

- Provider is unable, or the providers community environment is unsuitable to meet needs, which was not fully recognised or addressed in the stages above.

The learning themes and red flags are being shared with resettlement, hospital and community staff and also used to develop checklists for monitoring and assurances to guide a more intensive assessments and discharge process. By considering the themes and ensuring more comprehensive assessments that include details of specific areas that may be difficult to replicate in the community or behavioural challenges, alongside the use of a resettlement team to focus on more intensive in-put should reduce the likelihood of red flags emerging and therefore better outcomes.

Part 1

Key Learning & Recommendations:

1. Significant areas have been missed in the assessment process, in particular the exploration of behaviours that have become well-managed in the ward setting or by the MAH environment such as the impact of having easy access to open space, pods, sound proofing etc. These can be difficult to recognise and understand how these translate to a new setting or replicate in community placements settings. Involving Psychology in

the assessment process is being established to improve the assessment around identifying and managing behaviours.

2. Patients have been long stay in hospital where needs have often been met and well managed for many years due to staff knowledge, experience and adaptations to the environment. Changing the environment (ie a move to any new environment) can pose new or a return to previous behaviours that had settled.

3. Listening to families and carers needs to be a core focus, ELP can aid this communication and sharing of information. Families often have previous experiences and insight into life for the patient prior to hospital or on previous placements and these are valuable insights and learning.

4. Use of Psychological services at a much earlier stage, i.e. to be included in the assessment process, to aid understanding of how changes to the environment may impact upon behaviours, identify concerns and support the team with an early intervention approach and therefore reduce crisis working.

5. Placements have routinely been identified prior to the completion of full / formal assessments, The assessment of need must be completed including a psychological and sensory approach to aspects of care that may be challenging. This should be in place before a final decision on a placement can be made. Decision making on a placement should be based on the assessment of need and not on the ‘availability’ of a placement opportunity.

6. The standard assessment and care planning process has not been sufficient or supported with enough staff to intensively assess and review placements to ensure they are successful. The lack of an intensive approach has led to crisis situations developing, which are in turn are more difficult to correct and a drain on resources at a different stage.

7. When a provider's team has lost confidence in their ability to meet the needs of the service user, the placement will be unlikely to succeed and it could potentially be detrimental to the service user to remain in an environment where the staff feel unable to manage, we have seen examples where staff can withdraw and become fearful.

8. Model for Supported Housing, originated from supporting those with less complex needs (which was a significant success). When the complexity of need increased the skills, training, Trust in-put and potentially salary scale need reviewed.

9. Development of a resettlement service which can engage in a high intensity, low volume approach, facilitating intensive working with a smaller caseload and staying with the patient, their family /carer and the provider from assessment to post discharge remains the most rigorous way to co-ordinate care and support for all involved.

10. For Trusts to support providers with a constructive, open and transparent approach will achieve the best outcomes

11. Communication is a repeated theme, as with any complex discharge, it requires working across hospital, community, provider, carers and the service user. The communication between multiple agencies benefits

significantly from a dedicated individual with the responsibility to have an oversight between hospital and community settings. To manage, co-ordinate and ensure the comprehensive assessment, discharge and care planning – a resettlement team or service is best placed to support the MDT, however, this will be dependent upon the resource and therefore capacity of the service to meet this level of work.

12. Staff consistency in the ISP team is key to effective communication, building relationships, understanding behaviours and improves the understanding and application of Care Plans.

13. Confidence of a provider to meet needs, prior to the trial placement, does not predetermine whether the placement will succeed. The Trust assessment of need must determine what is needed and the provider evidence how this is to be met.

14. Dynamics between service users' requires more detailed exploration before shared placements commence. Shared placements create a dynamic that appears to have developed from a history of institutionalised care and should not be promoted unless there is a specific request by service users to share.

15. The development of Essential Lifestyle Plans (ELPs) to capture what is important in a service user's day-to-day quality of life, such as hobbies, likes and dislikes, (in addition to the care needs identified in a care plan) were not in place and information shared verbally was being 'lost' with staff changes early in the placements.

16. Provider in-reach checklists to improve in-reach and to ensure providers are familiar with service users in different environments (i.e. out of the ward, community settings, day care, outings, hairdressers).

17. Training needs for ISP staff teams must be identified as early as possible in the discharge planning process to minimise delays and improve in-reach learning.

18. Previous failed placements for a service user should be reviewed and used as learning to lead any new assessment process for discharge.

19. While a patient may be medically fit for discharge it may be that the resettlement of a number of long stay patients, particularly those with previous failed placements, are likely to require a bespoke environment and staff trained to a level that may not currently be available in a community setting.

20. Statutory services should be targeted to provide services and support the patients with the most complex needs, which would require the development of new settings / services. The current community provision has resulted in the majority of complex patients being reliant upon and discharged to non-statutory providers of Supported Housing and Nursing Care. An options summary to identify potential future developments could explore this further.

21. Recent experience of PBS Support is that it is currently best managed by the Trust and in-reached to the ISP. Providers in Northern Ireland have not developed sufficiently to ensure effective internal PBS services.

22. More collaborative working between community psychological/behavioural services and hospital services from assessment onwards. This will facilitate a more co-ordinated approach, greater understanding of the patient's needs at an early stage. Opportunities for community staff to work with the patient prior to discharge will strengthen skills and confidence and lead to better outcomes

23. The need for a patient to return to hospital for a short period during a trial period should not always be viewed negatively and can allow a Provider time to rebuild their team and can lead to discharge

24. ISP to have a greater awareness of PBS and ensure it is embedded throughout all aspect of their organisation as well as recognition that manager/deputies need to support staff though practice leadership.

Flags to Placement Breakdown:

The following list should be treated as 'red flags' and require immediate action to resolve, support the provider and closely monitor the placement until there is improvement or the change required.

Check for;

1. Incident reports; from the ISP in particular staff injuries, medication errors and each report should be scrutinised by the Trust along with the ISP, preferably by way of a meeting with the provider rather than email communication.

2. Medication errors, including either repeated errors or incorrect transcription of medication may have a negative and potentially serious consequence for the service users.

3. Lack of incident reports; under reporting can be equally significant. It would be unusual for a complex discharge at this stage of resettlement to have no incident reports from a provider. Trust staff on the ground have heard verbal reports of problems, which then need to be checked against the receipt of an incident report or ASG referral. Again, email communication for responses and action from the provider will limit the assurance process.

4. Members of ISP staff withdrawing from working with a service user, it has been reported on several occasions that staff have refused to work with an individual, once this occurs, it has the potential to expand across the team, leaving the placement unviable.

5. Higher than usual or increasing vacancies in a service or key people leaving the service, i.e. Manager, preferred Support Worker, in particular just before or during the early stage of transition. A decision may need to be taken as to the stability of the service to continue the transition and a monitoring and support process initiated between the Trust and the ISP.

6. Changes to support staff, as this will impact consistency and care. It is likely that new or re-allocated staff usually will not have received the initial training and information provided, this should be checked and addressed.

7. Service User getting out to activities other than with family or carers.

8. Family / Carers flagging issues are a priority, even if it appears at a relatively low level – as it can signify the start of problems and should be thoroughly explored, again with face to face follow up as the preference.

9. Changes to out-reach can be a flag, for example if it has stopped, reduced and then needs re-started or where there may be a difference of opinion between ISP and hospital staff

10. Concerned feedback from Ward staff regarding provider staff in-put during out-reach, i.e. not being involved, waiting outside, or signs of limited engagement

11. Incomplete parts of the care plan: day care placement not available or delayed, in-reach or out-reach aims not achieved prior to starting placement.

12. Lack of, or communication problems with any involved person or agency; Trust, family/carer and providers. Including a reliance on email rather than visits or meetings.

13. Checking for the main form of communication between provider and family, checking with both parties to ensure consistent and appropriate communication, i.e. not reliant on text messaging

14. Check for any inconsistency between Providers' expectations with what the hospital or Trust can provide. Inconsistencies should be identified and addressed as early as possible and appropriate contingency plans agreed.

15. Concerns raised by Carer or patient advocate

16. Day-to-day signs in the new accommodation, such as cleanliness of the room, housekeeping issues, contents of the person’s cupboards, fridge or freezer, quality of meals, snacks and hygiene, should include feedback from family / carers.

17. Medication administration sheets have they been filled out correctly, has it been checked / reviewed, responsibility and process needs agreed as part of discharge planning process.

18. The Positive Behaviour Support (PBS) plan is a key document. Regular, preferably weekly checks are required to ensure it is being followed appropriately, that there are staffing in place to meet the plan and staff are actively engaging in the plan. Providers lack of, or inability to meet the PBS plan has been a feature of several failed placements.

Part 2

Example Section (Limited Circulation, contains patient references)

Problem identified in SEA Process	Narrative	Learning
P254		
Ending or delays to in-reach can have a negative impact.	A provider alerted the Trust during an early transition stage that they no longer had the staff team to support the transition. This led to a suspension of in-reach for 7 months, during which time there was no direct contact between the patient and the provider. Patient was described by ward staff as 'anxious and confused' by in-reach ending.	Circumstances outside of the providers and Trust's control can emerge during a transition. A patient may have a very limited understanding of what has occurred or why the transition has stopped. This can lead to changes in behaviours and can potentially effect also how the person manages a re-start or future transition. Some limited, structured in-reach to continue relationship building may be more advisable than a complete withdrawal, if possible.

How to manage a 'breath holding' behaviour	Patient was previously known to 'hold his breath' while an in-patient, patient then fell during the behaviour Information on breath holding was not included in the assessment or care plan Patient's mother was unaware of previous incidents of breath holding while an in-patient. Provider did not have a plan or PBS to safely manage the breath holding behaviour.	Assessments and care planning need to include all potential risk behaviours, even if they have only occurred once or twice before or several years ago. Assessments require more detailed and historical checks of behaviours. Information should be shared with carers.
Use of vehicles	Retrospectively the Trust and family believed the vehicle was 'over-used' and that outings could be day long and late at night. (Note: at SEA provider disagreed). The car use was not flagged as a concern until the placement ended.	A PBS plan should be considered for use of transport, in particular if it should be linked with managing behaviours. Suspected 'overuse' needs to be addressed.

	It was reported that the patient was regularly in the car all day, returning to the unit only for meals and medication.	That the use of a car could potentially become a restrictive practice and would therefore need reviewed and be part of care planning.
Provider had 3 staff on sick leave, due to injuries sustained from the patient.	There was an increase in behaviours during the months after admission to the provider, the Trust initially believed these were manageable Provider had requested support from the Trust when they started having staff difficulties and without wraparound support, they subsequently advised the Trust they could no longer meet the patient's needs. Provider asked for admission to MAH. Trust staff were sent to the provider, providers staff withdrew from direct care.	Where there are significant staff injuries, the Trust needs to respond rapidly. Where a Care Plan or assessment identifies that staff injuries can be a feature, the assessment for the placement will require more intensive work, including Psychology to determine if a placement is suitable. Use of reflective practice, learning for teams, contingency planning, PBS support. Building of community providers resilience and capacity to manage behaviours that challenge. This can be through a forum for providers

		led by the Trust and on an individual team development basis. Establish an early intervention and preventative approach by earlier involvement with Psychological services.
Recruitment difficulties	Provider had on-going recruitment problems, began during the first transition and repeated later. Provider described their service as a charitable organisation with financial limitations. Provider increased pay scale to attract new staff.	The robustness of a service and a provider should be considered as part of the decision making process in discharge planning. A review of pay for Social Care / Supported Housing staff
Assessment of need and care planning of staff ratios	Care Plan indicated 2:1, staffing levels were later reassessed to increase during the trial to 3:1, this was not possible by the provider. Behaviours continued to escalate and the situation became unmanageable for the provider.	It was agreed at the SEA that the initial care planning should have been for 3:1 staffing. More intensive work on assessments and care planning required.

	It was acknowledged that the care plan should have been reviewed sooner.	When concerns arise, a review of the care plan and interventions need to happen sooner, or ideally to avoid reaching crisis stage.
Impact of physical health on behaviour change and placements	Patient had dental pain prior to placement breakdown. It is possible that dental pain contributed towards the escalation in behaviours	Physical pain and physical health care needs can add a further dynamic towards the end of placement.
Communication Contact with carer / family	The SEA described that 'communication between all parties declined during the last few months, including prior to and during the placement'. Patient's carer described 'not feeling listened to' about 'triggers' and previous incidents and that they wanted a closer working relationship with the keyworker. Carer described feeling 'isolated' from the communication between the hospital and the provider.	Effective communication remains a consistent area for improvement in resettling patients. The development of a resettlement team to manage communication and contact with carers has been proposed.

	Details of incidents need recorded in the care plan	
In-reach meetings	Carer fed back that there were too many staff at the discharge meetings and they became less effective.	Smaller groups of staff with more effective decision making, clear responsibilities and engagement process.
Assessment	Some behaviours and incidents were not fully addressed in the Care Plan and assessment information from the hospital had gaps flagged in the SEA.	The involvement of a Behaviour Specialist would improve the initial decision making about the placement.
Community Team involvement	The SEA described limited involvement prior to placement and therefore relationships or knowledge of the patient and carer were not well developed.	More comprehensive and detailed involvement is required to support patients with more complex needs. Community Teams have limited resources and have experienced difficulty in providing the level of support required to manage the complexity robustly during transition. Use of a resettlement service to improve involvement with a high

		intensity approach and the capacity to manage more complex, detailed assessments and discharge planning.
2 P256 (BT)		
Wifi took time to set up, was not ready for start of the placement.	Communication about the readiness of the Wifi between the Trust and provider.	All aspects that are of high importance to an individual's quality of life should be clearly identified and in place prior to discharge. Use of Essential Lifestyle Plans to promote person centred working and promote what is important to service users.
Wifi leads were subsequently damaged by service user.		Where something has been damaged, it should be a priority to be followed up to ensure it is in place.
Day Centre was a key part of the community package.	The Day Care assessment had not taken place and placement was not confirmed. Therefore the patient was on trial without this in place for 3 months.	Key decisions about whether the placement should proceed without day care in place need to be made as they are potentially pivotal to the placements success.

		Decisions and preparations for community Day Care should be in place and where possible commenced prior to discharge.
TV broken by service user.	TV was in place but broken on the first day of the placement. Replacement TVs were also damaged. The MDT assessment indicated that there was a require to enclose the TV, family fed back that the service user did not damage the TV at home. The decision that the service user would not damage their own TV was incorrect. A protected 'boxed' TV was then required which took several weeks to put in place.	Contingency plans for replacement of key items of significance to the individual should be discussed in advance and followed up immediately. Behaviours in a ward or family home setting are not guaranteed to translate to a placement setting, a low risk approach needs considered.
In-reach from provider – it was identified that the provider did not take the patient out during the in-reach phase and therefore ISP staff sat in bedroom using computer tablets rather than using the	In-reach Out reach Guidelines are in place and discussion was held on the ward, but concerns about the in-reach do not appear to have been acted upon or possibly communicated between hospital, community and provider.	In-reach work must be well managed and co-ordinated between Trust, including a resettlement team, Ward staff and ISP through regular and potentially weekly meetings with provider, ward and community – this should

opportunity to learn how to meet outdoor needs.	This translated into provider staff lacking confidence to take the service user out, which was not flagged by the provider.	be led by resettlement staff. The quality and structure of in-reach needs close monitoring. Development of a resettlement team with the capacity to work more intensively. Written agreements and expectations should be developed, with a checklist for each person to ensure that activities and daily living tasks are regularly observed and tried out with support by the provider staff. A record of provider attendance maintained by the ward for review and payment.
Sudden rise in vacancies and loss of key staff, such as a Team Lead, manager, preferred keyworker.	Unstable workforces lead to a high turnover and reduces staff consistency - key to building relationships and managing complex behaviours.	Vacancies should be seen as red flags and may be a deciding factor in delaying a placement. Monitoring that care plans and PBS plans are in place and being followed.

	Negative effect on communication and training, as knowledge from previous training and experience built up has been lost.	
Staff were reported by family and Trust staff going in as fearful of working with the some of the behaviours and therefore impacting on their relationship with the service user. Where injuries are occurring in the providers team.	Injuries to several staff in a team should be taken as a flag and additional support and training may be required, potentially the re-start of in-reach. This can lead to a rapid deterioration in relationships and breakdown with the provider.	Where relationships with a service user and a staff team are effected or broken down the placement is likely to be unsafe to continue. Decision-making must be made in the service users best interests, which may be to end the placement.
Concerns raised by family to the provider.	Examples ranging from: staff use of mobile phones in work, responsibility for cleanliness of the persons room or apartment, experience of staff for preparing meals.	Attention and engagement with carers to feedback on the service provider should be managed and led by Community staff. Resettlement service to be developed to have the capacity to engage intensively with carers and providers.
Failure to provide incident reports.	Incidents had occurred without Trust staff being made aware by the provider, giving a different perspective on the placement, i.e.	Referred to Contracts Department and provider reminded of contractual agreement.

	that the placement was becoming more settled. That incident reports were differing from staff accounts about the severity of the incident.	
Medication Errors.	A transcribing problem by the provider and no mechanism to check the transcription by hospital or community staff resulted in a service user being on incorrect / lowered medication for 7 weeks.	Separate medication SEA to establish a process to prevent this occurring in the future.
Environment.	Aspects of living environment not suitable for service user.	Full inspection of placement to be completed in advance of service user visits to ensure it meets service user's needs. Changes to be made before service user moves to placement.
Housekeeping errors.	Family were not provided a key to access the apartment, only a fob to access the garden, leaving family and service user waiting outside for staff.	Discharge planning to ensure all housekeeping arrangements such as keys, access to the building are in place and reviewed.

	Access was routinely delayed by up to 20 minutes leaving the carer with no access to the building – leading to the service user to become frustrated and the situation became a trigger for behaviours. The lack of access was compounded by family being unable to get a response to a single phone line which was constantly engaged.	Checks would be advised that assurances for access and keys are in place. Phone lines need to be considered and agreed to ensure the service can be contacted.
Feedback from Advocate.	Advocate felt that hospital discharge was the priority and that other patients had previously been given more time and support.	Followed up through complaints process and additional monitoring
Community Services had flagged concerns about the complexity and number of service users in one setting.	The service model of 12 placements was recognised by Community staff as reaching a limit about 6/7th admission, so the maximum number of complex service users with behaviours that challenge in one setting should be considered to not exceed approx 5-6 tenants.	Learning that when staff are flagging concerns, original plans may need to be reviewed. The development of new services, specifically for complex service users should take the learning of maximum numbers into account.

Transfer to Community Services at the end of Out-reach by ward staff.	The handover between hospital and community staff requires clearly defined roles, responsibilities and expectations. A detailed knowledge of the patient, carers the provider and the care plan are essential to supporting the hospital discharge	Clear roles and responsibilities. The caseload capacity and availability of community staff expected to manage complex discharges needs further consideration. An alternative would be to manage through a developed Resettlement Service with the capacity to provide more intensive monitoring and working.
Physical health	Patient had a number of known and outstanding physical health issues that were being treated and monitored by community GP. These health issues were previously known to lead to deteriorations in behaviours, which was shared with the provider.	Impact of physical health care and needs on placement breakdown were being monitored and may have been a contributory factor.
P257 (NT)		
Communication between provider and family.	Provider communicated with family primarily via text.	Communication by phone call and meetings is often more appropriate. A dependence upon text communication signifies there may be issues around communication.

Communication of changes between Trust and family.	Family unable to attend a meeting where delayed discharge was discussed.	Family must be informed by telephone or in person regarding the details of the meeting.
Co-tenanting and assessments	Two patients for planned transition from the same ward. No evidence from the ward to suggest there had been historical issues. However, the ward environment was large and two patients had no or limited interactions – this did not translate to the new, much smaller shared setting.	A formal compatibility Assessment to be considered when sharing houses. Even with further assessment it will remain difficult to fully assess the dynamic or relationship between 2 people while in the ward setting and also how this translates into a different environment. Sharing houses should not be considered as 'normal' practice. In-Reach could be tried with patients together in communal areas to see how they interact. Involve Psychology

When sharing a house, different timeframes for transitioning may impact the outcome.	Both patients were originally to transition within a few weeks of each other. Delayed for one patient due to provider staff requiring training in physical intervention model. The result was that one person moved into the bungalow first and had several months living in the house without sharing the space or staff team.	More comprehensive assessments would have identified that the provider required the physical intervention training and the delay could have been avoided. If there are delays to an original plan, a reassessment on dynamics and the shared space should be considered. If sharing is unavoidable, contingency plans need to be in place.
In-reach	In-Reach was done on individual basis for patients who were going to be sharing a house. Once on placement the other Trust's PBS became involved	PBS staff from another Trust should be involved as part of the assessment and in-reach to the ward
Termination of a trial placement by the provider	The provider had ended the ward outreach the week before and there had been no further formal contact or flagging that there were problems	The provider ending the in-reach was taken as a positive, it has been custom and practice that the other Trust should follow up with contacts.

	with the placement or between the individuals. The family were contacted by the provider to advise that the placement was being withdrawn that day. This happened before Trust staff were made aware (provider had left messages for Trust).	Resettlement Team should continue with a high level of contact for assurances during the trial leave. A clear understanding of who to report to while on trial leave should be given to providers.
Family investment in new home	The family had spent considerable time and cost preparing the bedroom and contributing to the shared spaces in the house.	Ensure in advance that there is an agreement and discussion with family regarding belongings and expenses.
4 P258 (NT)		
Transition	It was acknowledged by the originator Trust that in part, the transition had been based on an opportunity for a placement arising and pressure felt by the originator Trust from the Department to identify placements	Placements must be based on assessed need and not an opportunity for a placement. It is now widely accepted that all discharge planning must be based on comprehensive assessments.
Changes in key staff	Keyworker who had developed a good rapport and was seen as a	While it is not possible to stop this from happening, the impact needs

	leader within the team left during the trial for a new post	to be recognised and monitored closely.
Vacancies in the staff team	A number of staff started leaving during the leave on trial, initially this was not believed to be connected As incidents occurred during the trial leave staff went out sick and others continued to leave, with 12 staff in total leaving.	Comprehensive assessments should include impact on staff teams and potential risk Staff vacancies are a flag and should be monitored closely throughout placements. Incidents and sick leave are flags and will require action, support for the provider and a review of the package. Supports may not be able to maintain package where critical numbers of staff have left.
Use of non-core or 'satellite units' for service users who require additional staff at short notice	When additional staff are required to supplement the support / care package it needs to be close enough to make this possible. Staff were unable to respond quickly from the core unit	Where additional staff are required at short notice, this needs to be part of the same complex and not a satellite unit.

Environment	There was only one door into the property and no rear exit, a staff member went out a rear window due to concerns and no alternative exit strategy.	Comprehensive assessment of properties is required, the property should be discounted or adapted to meet needs. Psychology should be invited to bring in the behavioural aspect to OT environmental assessments. Assessments should be made on the basis of managing a 'challenging day', if the environment is unsuitable for that instance then it needs reviewed.
Provider experience of incidents during in-reach	Community time with the service user and the provider staff was not included in the in-reach, therefore there had been limited exposure or experience to some of the risks and behaviours that later started during the leave on trial. The provider team had limited experience of the potential for aggressive behaviours during the in-reach phase.	The quality and breadth of in-reach experience must be managed and monitored before trial leave commences. Where possible provider staff should gain experience of the behaviours that challenge as part of getting to know the person.

Provider expectation of Trust support and provider ability to manage complex behaviours	Providers team appeared to have difficulty recognising triggers to behaviour. When Hospital PBS staff were there, situations were managed, once the PBS staff started to withdraw the team had difficulty managing behaviours that challenged or to identify potential situations and triggers prior to escalation. A weekend visit to an animal sanctuary had been arranged by staff, no-one had phoned ahead to confirm opening or review the environment. Staff arrived and the centre was closed, which was a trigger to escalated behaviours.	Trust does not have wraparound or intensive support to provide additional support out of hours in the community. Additional training and support in PBS for providers Post incident de-briefs for staff should be in place with the provider and if developed sufficiently, the Resettlement Team, PBS or community staff from Trust to join these. A recognition that the current Supported Housing model may not be able to meet the more complex needs of service users at this stage of resettlement. And that staff development and skill level will need to be considered.
5 P259 (NT)		
Concerns raised by ward or community staff during discharge planning require thorough	Staff and medical team had flagged concerns about the patient's	Documentary evidence of previous offers and plans and that the leave on trial was contrary to medical

assessment, which may in some cases delay or prevent discharges.	planned discharge to family's home. A meeting had been held between the originator Trust and DLS but the concerns were unable to be fully evidenced in the information given to DLS and therefore the guidance from DLS was there were insufficient grounds to prevent discharge at the family's request.	advice require clear documentation and must be shared with family / carer. Decision making by DLS will be on the basis of evidence provided, therefore detailed history of incidences, previous offers of support and family ability to meet needs should have been available. A social history report completed by Social Work and documentation outlining the discharge being contrary to medical advice may have improved the decision making. An assessment of the family plan and environment to meet the persons needs could have been explored. Delay to a discharge on the basis of a more intensive assessment and review of work with a family / carer should be discussed and a reasonable delay to facilitate that work, to be considered acceptable.

		In the event that a situation could re-occur, detailed contingency planning should be in place and shared with the family prior to discharge
Lack of services in a specific area	Family had requested a Domiciliary Package to supplement support at home, when the Trust went to source a package, unfortunately there were no providers or service available in the area	The availability of community packages of care should be established early in the discharge process.
Funding for meals at day care	Day centre requested £2 towards a daily meal at lunch time, family declined.	Any costs attached to day care or activities need to be transparent and fully resolved prior to leave on trial
Community visits to review leave on trial	During leave on trial the family declined offers to meet with the originator Trust. Further visits to the home were carried out, but the Team were unable to gain access to see the patient or assess the family's ability to meet his needs. All contact with community services was via the telephone or outside the	Expectations and agreed access need confirmed as part of the discharge plan. If a family or carer is unwilling or fails to provide access and review, legal guidance should be sought.

	house, so no staff were able to observe the home situation.	
6 P260 (BT)		
Assessment of noise disturbance in the community environment While day time shouting was being managed, it was the continuation overnight that had the most significant impact and kept others awake.	Placement was suitable and appropriate and did meet nursing needs. The impact of the change in environment was not fully recognised and noise levels that are tolerated in a ward setting did not transfer well to the settled community placement. Once in the environment, the impact of the patient shouting became a significant problem for the other residents already in the home. Bedroom was at the end of a corridor behind double doors and separated from other bedrooms, it was hoped these factors would have mitigated against the sound / impact on others	More detailed environmental assessments are required where noise is identified. Environmental assessments carried out by OTs should be extended to include PBS and Psychology to assess the interrelational connection between environment and behaviour. Adaptations or sound proofing of buildings may be required to meet specific needs. Assessment and discharge planning need to acknowledge that MAH Wards are sound proofed and often busy active areas.

	It was also a small unit with 5 other, well established and settled residents, this was a quiet environment and constructed as a standard build bungalow with no sound proofing. The day time shouting was being managed by the patient spending more time in their bedroom and eating separately to other residents, which impacted the persons experience of the placement and did not promote settling in to the new environment.	
In-reach needs to have a structure and monitoring of the activity	Noise disturbance and difficulty with the transition may have been better recognised had the provider engaged in a more 'hands on' in-reach.	During SEAs the quality of in-reach has been cited as a problem. Often this information is not apparent until retrospectively reviewed The progress and review of in-reach work requires much closer monitoring. This would be best achieved with support to ward managers from community or resettlement team

		A checklist of activities and experiences needs to be developed which can be adapted for each individual and used to support ward staff and providers manage the in-reach and where this is incomplete a flag for extending in-reach.

HOMES NOT HOSPITALS

An analysis of barriers and learning to support people with a learning disability and/or autism who display behaviours that challenge including those with a mental health condition

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Reminder Of Why We Are Here: Service Model (by 31st March 2020)

People with complex learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition (*1) should:

- Be supported to have a **good and meaningful life**, with access to activities & support to sustain relationships;
- Receive care and support which is **person-centred, planned, pro-active & co-ordinated**
- Have **choice & control** over how their health and care needs are met & strong independent advocacy
- Be supported to live in the community **with support from/for family & carers**, as well as their care team, including training and respite
- Have choice about **where and with whom they live**
- Be able to **access specialist health & social care support in community** (including intensive 24/7 support as required)
- Access, if required, to **high quality assessment & treatment in hospital** setting with **discharge planning starting from point of admission**
- Have access if required to **Community forensic health & care** to support people who may pose a risk to others

The Review Team (*2) recommendations:

- **Ordinary lives require extraordinary supports**
- **A life course vision of services** for people with learning disabilities and autism is required

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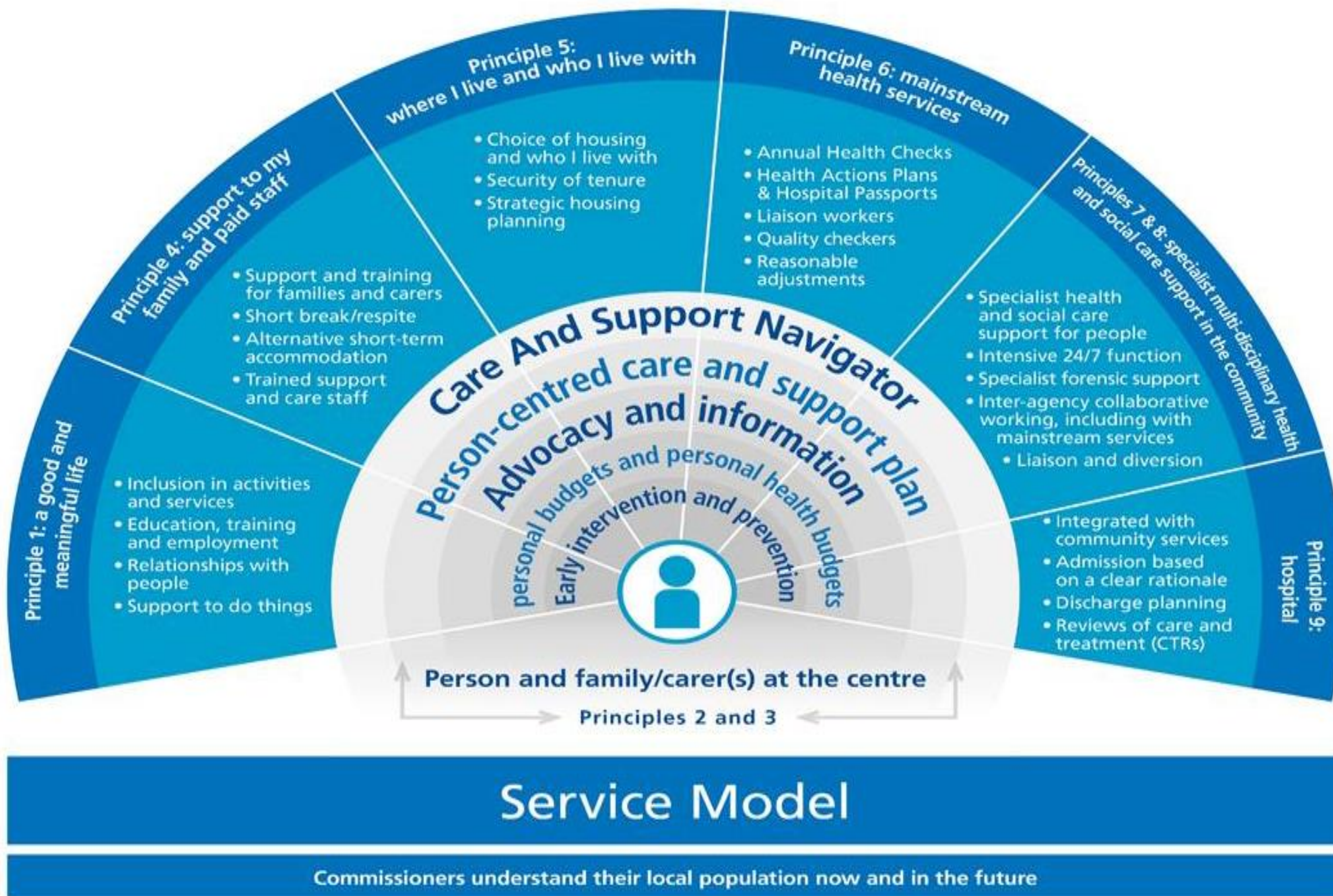
*1: NHS England – Building the right support – the National Service Model
*2: A Way to Go – A Review of Safeguarding at MAH

National Service Model (NHS England, 2015)

" The success in this lies not within systems and processes but within human connections, commitments, accountability and sustainable relationships that are non-adversarial." (Commissioner)



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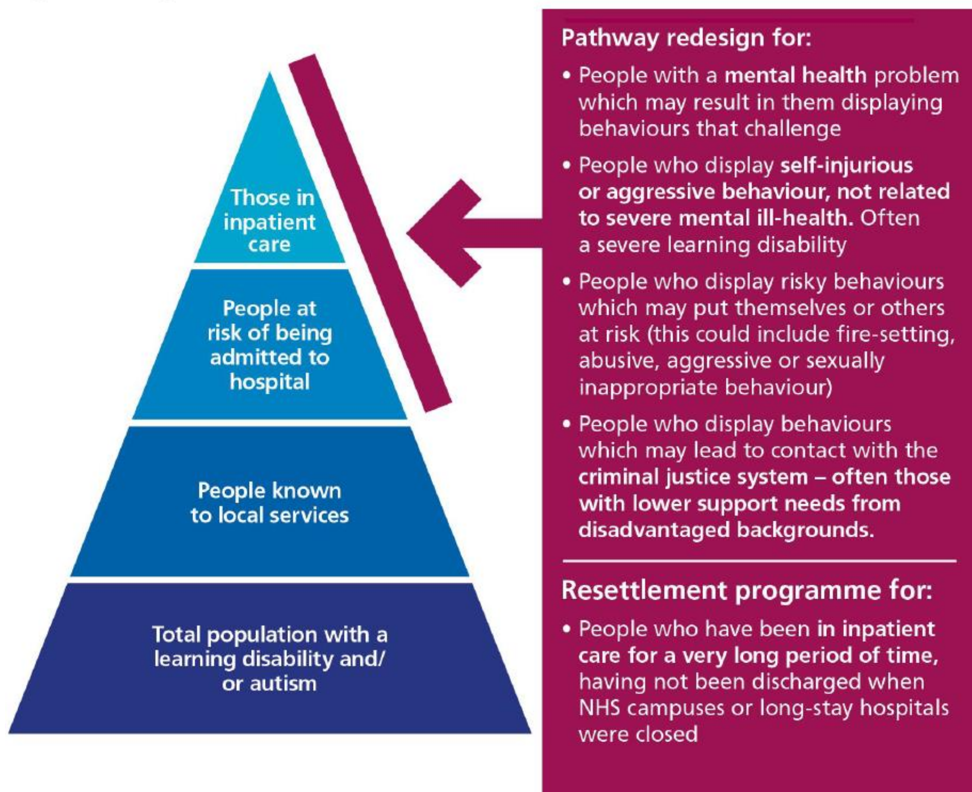
People For Whom We Need New Services For*:

'Challenge is as much about preventing new admissions ..and providing alternative care and support, as it is about discharging those individuals currently in hospital.'



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* Building the right support NHS England

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Key recommendations from East London Foundation Trust August 2019 (BHSCT)

- **Addressing Restrictive Practices**
- **Development Of Robust Community Services**
  - Home Treatment
  - Crisis Services
  - Long Term Accommodation and Support Plan
  - Joint Working With Adult Mental Health Services
- **Provider Development**
  - Collaborative Models Of Working Together
  - Training and Skills Development

PROGRESS

- **Developed a systematic approach to reducing restrictive practices**
  - New Policy Developed and implemented in August 2019
  - Significant Reduction In Use Of Seclusion
  - Detailed Metrics Developed and Monitored Weekly – MAH Safety Report

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Key recommendations from East London Foundation Trust August 2019 (BHSCT)

PROGRESS (cont)

- Community Teams Being Restructured To Meet Needs
- Home Treatment and Crisis Support Service In Development
- Accommodation and Support Plan In Place
- Joint Working With AMH In Place Since 2018

PROVIDER DEVELOPMENT

- Meetings With All Providers To Establish Baselines Completed
- Quarterly Workshops Established To Share Information and Support Planning

ENGAGEMENT & PPI

- Joint Working Structure With Carers Developed Communication Strategy With Wider Communities of Interest

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RESETTLEMENT JOURNEY SO FAR …… THE LEARNING

- DHSSP 1995 target that everyone living in a long stay hospital should be resettled by March 2002. (878 NI) Reduction of 48% achieved.
- 2002 Bamford Review Equal Lives – Progress needs to be accelerated on establishing a new model … based on integration.
- Progress on resettlement 2002-2011 – approximately 210 individuals resettled. Reduction of 75% of targets set.
- NIAO/Bamford Review reports identify why the resettlement programme was slower than intended
  - Insufficient resources to fund alternative forms of provision
  - Absence of robust implementation mechanisms to hold agencies to account
  - A perception that the needs of learning disabled people could be met in their entirety by Health and Social Services
  - An underdeveloped culture of involving learning disabled people and family carers in decisions about service available to them and that they wanted to receive
  - Absence of a co-ordinated programme of follow up and evaluation
  - Market for resettlement services had not been developed properly through open procurement CT

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Cont.

- Target date was reset to 31st March 2015. An updated action plan covering period 2012-2015 was approved. This contained actions to be taken under the heading Supporting People. A new LD Service Framework was published – 33 standards including
  - The need for involvement by people with learning disabilities, their carers and their families by promoting social inclusion, reducing inequalities in H&SC, well-being and improving the quality of care
  - Information communication between agencies and with people with LDs and families
  - Access to self-directed support, advocacy services and support to maintain employment opportunities and meaningful day opportunities
  - Support to ensure their accommodation needs were addressed

- Between April 2012 – 31st March 2014 resettlement targets were fulfilled. 116 from the PLT list were resettled with 49 remaining by March 2015. 50% of these were living in Muckamore Abbey Hospital (28) Currently (9)
- Misalignment between Health and Housing Funding streams
- Absence of robust implementation mechanisms
- Absence of formal procurement arrangements for new community based services
- Improved structures were put in place in 2012 – these improved performance but ceased in 2015/16

2015 - Present

- Regional supported Housing plan (NIHE) – Priorities reset.
- Uncertainty about access to capital for housing.
- No additional supporting people funding. Trusts currently absorbing SP costs.
- Accessing privately secured capital to build housing – lack of guidance
- Average lead in for newly developed supported Housing 2 to 3 years.
- Need to review oversight and regulation arrangements

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Outline Of Barriers To Resettlement and BHSCT Proposals

Barrier: Community Infrastructure	Proposals
• There is a limited community service to provide either an intensive wraparound support or the flexibility to respond to prevent and manage crisis situations in the community. Currently Community Teams provide a 9-5 Monday to Friday service • The numbers of people being supported in the community alongside the population awaiting to be discharged, are increasingly complex, adding pressure to Teams and increasing the likelihood of unsuccessful placements / admission to hospital in the future • Current Community model does not provide accommodation based services for complex behavioural needs, this is commissioned externally. • Overnight respite provision is limited and there is no provision for people with more complex needs in the community. This is an unmet need that is essential to support families and carers to continue caring for family members at home.	• Development Community Treatment and Intensive Support Services • Enhancement of Positive Behavioural Support services (PBS) in the community is required to support staff and new accommodation based services to meet the needs of people already being discharged and into the future. MAH holds the most experienced and skilled PBS staff that can provide a learning opportunity for the development PBS practitioners. • Statutory Community model / services need to target and be able to meet the most complex needs. Development of 6 bed, high level statutory Supported Accommodation (Supported Housing) for people with behaviours that challenge – this would be at the highest level of need managed in the community • A specialist LD Nursing Care provider is planned (but not yet funded) to include 2 respite placements, this will be at high cost and a limited service (BHSCT only)

Barrier: Independent Sector Community Infrastructure	Proposals
• Community requires a stepped model of care ranging from Supported Housing to Learning Disability Nursing care • Providers capacity to manage the most complex cases • Number of people with complex and challenging needs in any one setting can lead to a dynamic in the scheme which can spiral quickly • Rapid expansion in the independent sector, driven by resettlement has resulted in an instability in an already fragile and limited market (see under staffing resources)	• Development of specialist LD Nursing Care in the community that can meet the needs of patients who have behaviours that services find the most challenging to manage (potential to develop with All Ireland Healthcare) • Development of small scale Supported Housing Schemes, maximum 6-10 places • Partnership working with independent sector to increase their capacity to manage through support, training and wraparound services • Recognition and support by Commissioner that funding needs to be made available for these revised service delivery requirements.

Outline Of Barriers To Resettlement and BHSCT Proposals

Barrier: Learning from Unsuccessful Placements	Proposals
• BHSCT has reviewed a number of the unsuccessful placements and there were 3 key common themes for improvement: i. Communication ii. Care Planning and Adherence to Care and PBS plans iii. Expectation of Provider and LD Services iv. Community Infrastructure v. Workforce both Trust and Independent Sector • Assessments are not sufficiently comprehensive to ensure robust discharge plans • Discharge Planning requires improvement and benchmarking against best practice, with increased involvement with families and carers • The use of Essential Lifestyle Plans (ELP) has been underdeveloped and can be dependent upon Trust • Communication with Carers on resettlement plans is insufficient or non-existent and is raised regularly as a failing for MAH and Trusts • BHSCT Community Service do not have the resources to allocate the staff or the time required to work more intensively with the remaining patients at MAH. This position is due to funding, vacancies and service pressures. • The current BHSCT resettlement model relies on 1WTE to co-ordinate discharges, this is an insufficient resource to complete the detailed work required • Ward staff are a limited resource and need to focus on managing ward based issues	A Transition/Resettlement Team is being proposed to enable the intensive assessment and discharge planning required between Hospital and Community. The Team would have the capacity to ensure the following are in place for each patient • Essential Lifestyle Plans • Detailed Care Plans • Carers Needs Assessments • Comprehensive Discharge Planning Process • Mental Capacity Act assessments • Declaratory Order completion • Structured and detailed management of in-reach and out-reach working with providers • Manage PBS Support • Comprehensive information shared with providers Families and Carers need to be supported to be involved throughout the discharge planning and that their knowledge of their family member is both central and should be clearly evident through ELP and Discharge Planning. The implementation of a Resettlement Support Team is being progressed which will coordinate and take responsibility for the successful placement of each patient. It will place patients and carers at the core of their work. Risk to be flagged: that developing a resettlement model may negatively impact staff resources elsewhere. A detailed review of the position on assessments, ELP, Carers Assessments and any legal processes required, is underway. Communication Strategy for staff, families and patients is being developed for the Mallusk resettlement and this will need to spread across all resettlements Feedback from Carers is being responded to, initially through 'Resettlement Clinics' being offered to carers across December and January, with a view to extending further.

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Outline Of Barriers To Resettlement and BHSCT Proposals

Barrier: Timeframes required to develop new Community Services	Proposals
• The original proposed timeframes were an underestimation of the challenges involved in a large scale resettlement of patients with highly complex needs • Timeframe required for new Supported Housing schemes is usually around 3 years from SOC to OBC Planning, build and phased occupation. • The services could not have foreseen the difficulties in recruiting and retaining the staffing resources required. • Collapse of Regional Supported Housing Plan in November 2016 led to no new developments	• Many of the patients remaining in MAH require a bespoke environment and that this environment is as critical to meeting their needs successfully in the community as staff care. • Strategic Outline Cases have been developed and BHSCT are actively completing Full Business Cases. • Ongoing partnership work between NIHE/DoH & DfC is needed to sustain resettlement timeframes.
Barrier: Staffing Resources across LD Services (Hospital, Community, C&V)	**Proposals**
• There are insufficient staff available to meet the current and future demands on the LD sector across both statutory and non-statutory services, for eg: • Outreach work adding to the pressure on Muckamore nursing and care staff, which could be expected to escalate significantly during the opening of new schemes next year • Community Statutory LD Teams have significant vacancies and therefore limited resources • Statutory Accommodation based services experiencing exceptional recruitment and retention difficulties • The opening of a new development in Independent sector is de-stabilising the current provider as staff shift from one provider to the next • Pay: particularly relevant to C&V Supported Housing Sector, where the core staff (Support Worker) salaries are commensurate to a Band 2 grade, resulting in a low paid and unstable workforce • Staff movement in C&V leading to the loss of consistency of staff which for many patients is critical to their community success.	• A Learning Disability workforce planning strategy is required. • A regional approach to LD recruitment across all professions and support staff is required following the Muckamore review and its impact on staff morale and retention. • Trusts are working in partnership to meet with providers to address capacity • Contracts with providers will be reviewed to make expectations clearer • HR support to manage recruitment challenges • Regional forum and agreement to consider low paid working in this sector

Outline Of Barriers To Resettlement and BHSCT Proposals

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Barrier: Location of New Community Accommodation Based Services	Proposals
• New Accommodation based developments for a specific group of existing patients (approximately 8 patients) in a Trust area significantly increases the pressure and demand on the Community Service, there is an understandable reluctance for further development within each Trust area, • Patients in placements receiving services from a host Trust, again creates a pressure on other areas and who holds the responsibility for out of hours care needs • BHSCT has taken the lead on the submission of Business Cases	• A Regional forum for the agreement on the siting of new services • Agreement on the Regional Protocol for out of area placements and host Trust responsibilities

Barrier: Medical Cover Community and Hospital	Proposals
• Insufficient Consultant cover in the Community	• More innovative approaches to recruitment and retention

Summary Key Lessons For Effective Delivery Of Successful Resettlement/Transition/Prevent of Admission

- Robust Regional Housing and Health & Social Care co-ordination implementation mechanisms to hold agencies to account
- Carers and service users central to every part of process
- Joint working with Adult Mental Health
- Clinical leadership
- Supports for local teams
    - Strong leadership and sound governance
    - Commitment to joint working
    - Single SRO for development and delivery
    - Project management – understand the local population we are seeking to achieve better outcomes
    - Support with tools eg bespoke assessment and care planning, risk assessment
    - Regional cross trust MDT training learning and development programmes

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Investment Required To Deliver Successful Transition For People From Hospital To Home And To Prevent Unnecessary Admissions

Systematic learning from unsuccessful placements have highlighted the need for investment in:

- **Trust MDT teams (Core, Transitions, Intensive Treatment & Forensics)** to deliver agreed local and regional pathways (as required) with assessment and treatment services, forensic services & respite services;
- **Specialist Day Support services**, to ensure access to meaningful activities
- **Homes** – timescales & cost of planning, funding and implementing for current and future accommodation need with partners in C&V and private sector
- **Provider Development** – partnership working, performance management, contract & training
- **Workforce** – statutory, community & voluntary
- **Financial Planning** – scale of additional costs required

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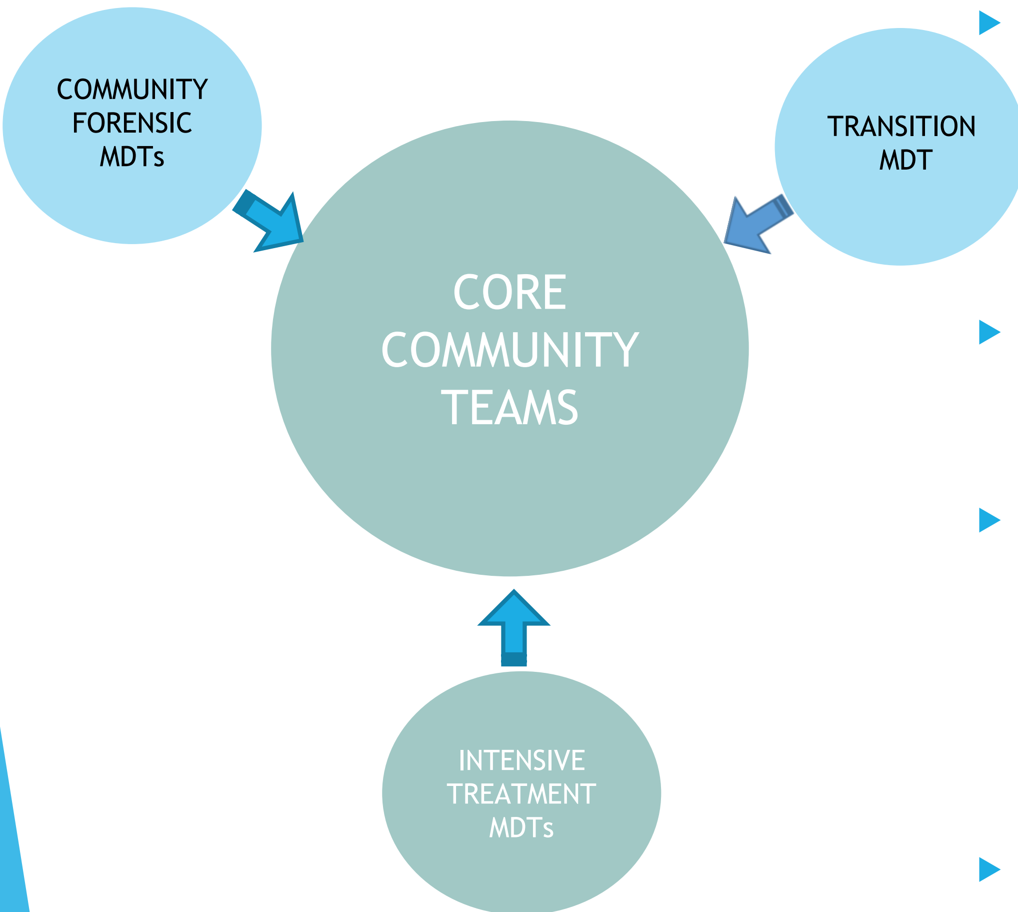
Development of Trust Community Multi-Disciplinary Teams



- **Core Community Teams** – the ongoing development and investment in MDT community teams to promote family support, independent living, physical & emotional wellbeing, risk & needs assessment, care planning & oversight and supporting discharge from admission;
- **Transitions Team** – (new) to deliver integrated planning between hospital, community & providers for the most complex individuals;
- **Community Learning Disability Intensive Treatment Team** to provide targeted support, including therapeutic support, for individuals in the community at times of escalating crisis/ during acute episodes (limited service funded, excluding therapeutic support, for existing community population);
- **Community Forensic MDT** – (new) to support individuals with specific forensic needs across Belfast Trust.

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Current Resettlement Position

- Muckamore – Number of Inpatients – 51 as at 12th February 2020 (3 on trial re-settlement)
- Patients under active treatment – 6
- BHSCT – 21 patients:
  - 2 trial leave
  - 1 February
  - 3 April – June 2020
  - 7 June – December 2020
  - 4 – Proposals being explored via SOC 2020/21
  - 4 Business Case developed and submitted 2023
- NHSCT – 21 patients:
  - 1 February
  - 4 April – June 2020
  - 11 June – December 2020
  - 5 Proposals being explored via SOC 2020/21
- SEHSCT – 10 patients:
  - 1 trial leave
  - 3 April – June 2020
  - 4 June to December 2020
  - 2 Proposals being explored
- ST – 1 patient (complex risk management)

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Current Resettlement Position

- Mallusk Supported Living Scheme (11 places) - Building work is due to complete in May/June 2020
- Bradley Court 11 place Specialist LD Nursing facility – Building work to be competed May 2020
- Pond Park Supported Housing Development (5) – Now ready to accept tenants
- BHSCT has 2 SOCs submitted to SP
    - Knockcairin Extension (10)
    - Mews Two (5)

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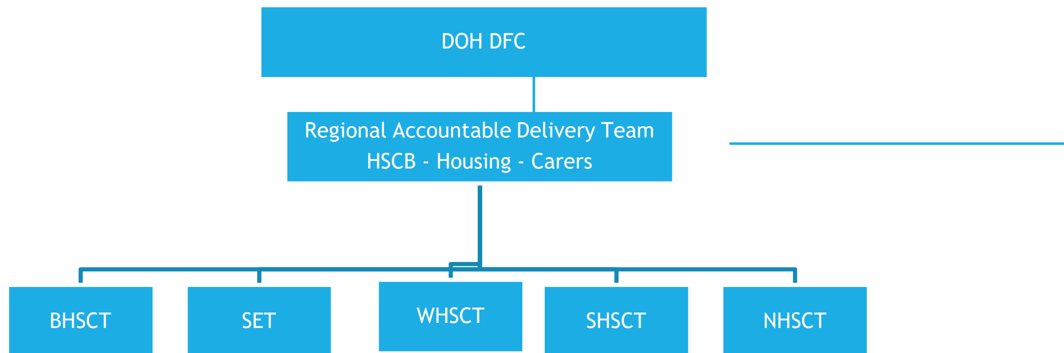
Building On Existing Structures and Expertise To Provide Transparency and Clarity



Functions

- Small high-skill dedicated team for 2/3 years
- Comprehensive regional plan
- Financial plan capital and revenue
- Workforce plan
- Performance management framework
- Provision of guidance to local teams
- Evaluation and monitoring outcomes
- Procurement and contracting development
- Develop guidance on community governance framework
- Developing clear information for carers

Functions – Low Volume/High Intensity

- Local implementation plans reviewed and challenged by Regional Group
- Development of local structured collaboratives
- Delivery of intensive high quality sustainable placement for every individual
- Carers and service users to be supported to co-produce plan – shift in power
- Re-design discharge planning processes with carers

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Failure Rate of Resettlement - 2019/20 Year To Date

The table below shows the failure rate of resettlement from 1st April 2019 to date. This has been calculated by excluding the patients who are currently in trial resettlement. For example, the BHSCT failure rate has been calculated using a denominator of 8 completed resettlements, of which 2 have failed.

	2019/20 Year To Date			
	Successful Resettlement - patient discharged	Failed Resettlement - patient returned to MAH	Ongoing Resettlement	Failure Rate
BHSCT	6	2	3	25%
NHSCT	6	3	0	33%
SEHSCT	1	0	1	0%
WHSCT	1	0	0	0%
Total	14	5	4	36%

Conclusions

- Ministerial support required
- All parties committed to people with learning disabilities living '**ordinary lives with extraordinary support**';
- Complex nature of remaining individuals in MAH (51 people in 2020 compared to 250 people in 2010) requiring intensive **specialist multi-agency supports**;
- Dedicated Accountable **Oversight Group** (Housing/Health & Social Care Trust & Commissioner) to lead change & secure resources for current & future populations.

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