MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON MONDAY, 24TH JUNE 2024 - DAY 96

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THE INQUIRY RESUMED ON MONDAY, 24TH JUNE 2024, AS FOLLOWS:

CHAIRPERSON: Ms. Kiley.

MS. KILEY: Good morning, Chair and Panel. 09:54

INTRODUCTION TO ORGANISATIONAL MODULE 6 RESETTLEMENT BY INQUIRY COUNSEL

MS. KILEY: As you know this morning we are moving on 09:54
to Organisational Module 6, Resettlement. And before we call our first witness, I just want to say a few words of introduction in respect of the module.

So, Chair, Panel, the purpose of this module is to 09:55
examine the mechanics and effectiveness of the process of resettlement, including receiving evidence from the Belfast Trust on the mechanics and effectiveness of the process of resettlement from the Northern Ireland Housing Executive on Infrastructure For Supported 09:55
Living, from the Northern Ireland Social Care Council, the NIGP Committee, and the Independent Health and Care Providers about their role, the role of their members in the resettlement process, and Consideration of the Independent Review of Learning Disability Resettlement 09:55
Programme in Northern Ireland, which is dated July 2022 and I'll say a little bit more about those matters shortly.

The module is of particular relevance to paragraph 16 of the Inquiry's Terms of Reference which requires the Inquiry to examine the adequacy and outworkings of the policy and process of discharge and resettlement of patients at MAH. 09:56

In this module the Inquiry has received eight statements from persons in various different organisations. They are firstly, Fiona Rowan, who was the resettlement lead at Muckamore Abbey Hospital 09:56 between September 2019 and June 2020; second, Patricia Higgins, who is the Chief Executive of the Northern Ireland Social Care Council, and I think when I refer to them in future I'll simply use the acronym which they're known by, which is the NISCC. The third 09:56 statement is from Dr. Alan Stout of the Northern Ireland General Practitioners Committee, the NIGPC; fourth, Dr. Marina Lupari, who is a Director of the Independent Health and Care Providers, IHCP; fifth, the Inquiry has received a statement from Fiona Boyle who 09:57 is a principal consultant of Fiona Boyle Consultants; sixth the Inquiry has received a statement from Bria Mongan, who is the co-author of the Independent Review of Learning Disability Resettlement Programme in Northern Ireland, July 2022. Seventh, the Inquiry has 09:57 received a statement from the co-author of that report also, Ian Sutherland; and eighth, finally, the Inquiry has received a statement from Elma Newbury MBE, who is the Regional Services Director of the Northern Ireland

Housing Executive.

I should say, Chair, that the first seven of the statements which I have referred to have been shared with CPs and have been published on the Inquiry's website. Unfortunately it has not been possible yet to share the eighth statement which I referred to, that of Ms. Elma Newbury of the Housing Executive. 09:57

Ms. Newbury's statement was received just last week on 18th June. It runs to 195 pages, including exhibits, and it is presently being processed by the Inquiry. It is anticipated that that will be shared this afternoon or tomorrow morning - hopefully the former, Chair - but on behalf of the Inquiry team I apologise to Core Participants that it hasn't been disclosed sooner, and it hasn't been possible to do that. Later on in my introduction I will say a little bit more in summarising the statement, and I should say that Ms. Newbury is not one of the witnesses from whom the Inquiry Panel wishes to receive oral evidence. 09:58 09:58 09:58

CHAIRPERSON: Okay.

MS. KILEY: So I'll return to Ms. Newbury's evidence in due course.

CHAIRPERSON: I repeat your apologies because -- although it did come in very late. 09:58

MS. KILEY: Yes.

CHAIRPERSON: So sorry to all CPs that they haven't had the chance of reviewing that yet. But you're going to summarise it and they'll get it later this week.

MS. KILEY: I am.
CHAIRPERSON: Okay.
MS. KILEY: Hopefully this afternoon, Chair.

I mentioned the witnesses that the Inquiry wishes to hear oral evidence from. So having considered the statements from the persons that I have referred to, the Inquiry Panel wish to hear oral evidence from the following four witnesses: First, Fiona Rowan, who will be giving evidence later this morning; second, Fiona Boyle, who will be giving evidence this afternoon, and then finally tomorrow morning from Ian Sutherland and Bria Mongan, and they will be giving their evidence together. 09:59

I should say that the statements of evidence that I've just referred to do not represent the totality of the evidence that the Inquiry has received to assist its consideration of the adequacy and outworkings of the policy and process of resettlement of patients at MAH. The Inquiry, of course, has already heard a substantial amount of evidence about resettlement from patients and their families as part of the patient experience phase of the Inquiry. Some of the evidence received from MAH staff also address this issue. 09:59 10:00

Resettlement was also an issue which featured in the evidence received by the Inquiry in the Evidence Modules, which ran last year from March to June 2023,

and as the resettlement policy and process had practical implications for the operation of Muckamore Abbey Hospital, it is anticipated that these matters will also feature significantly in the evidence to be received in Organisational Module 7 to 10 in fact, and witnesses in those modules have specifically been asked, where appropriate, to address issues around resettlement. So it is anticipated that we will hear more about this after the summer. 10:00 10:01

And the Inquiry will, of course, consider the totality of the evidence it receives on this topic. But it is important to say, Chair, and Panel, that the Inquiry's consideration of resettlement does not start and end with this module. 10:01

It is also important to acknowledge that the resettlement of patients from MAH is a policy and process that operated prior to the commencement of the Inquiry's Terms of Reference and indeed continues today. The Inquiry's examination of the issue for the current purposes must, however, be focussed on the timeframe and matters identified in the Terms of Reference. Whether or not the Panel eventually seeks further information on resettlement at a later stage will no doubt be considered by you, taking into account all the evidence heard to date. 10:01 10:01

Before we move to call the first witness, it would

perhaps be you useful if I highlight some of the salient features of the written statements of those witnesses from whom we will not be hearing oral evidence. So, firstly, can I turn to the statement of Patricia Higgins, who provided a statement on behalf of the Northern Ireland Social Care Council, NISCC, which is dated 13th March 2024. It has Inquiry reference STM-276. 10:02

Ms. Higgins explains that she has held the position of the Chief Executive of NISCC since 2018. Ms. Higgins also explains that NISCC is the regulator of social workers and the social care workers. She states that social care workers working within learning disability services who are employed in any setting specified by legislation are required to be registered with NISCC in order to practice. Entry to the Social Care Register does not require a qualification. 10:02

Ms. Higgins explains that NISCC has in place standards of conduct and practice for social workers. Social care workers must comply with those standards and they may be used as the basis of a Fitness to Practise investigation. 10:02

10:03

Ms. Higgins explains the training requirements for all registered social care workers. She states that she is not aware of any regional guidance on the skills needed by social care staff to care for patients with complex

needs, including autism and challenging behaviour, once patients are resettled into the community.

There are vocational qualifications available for staff working in health and social care, and Ms. Higgins explains that the health and social care diploma offers optional units for care workers working with adults with learning disability and autism. 10:03

Ms. Higgins also explains that NISCC has been working with the Department of Health to support the implementation of proposals to reform adult social care, and that includes the development of a vocational qualification framework. She also notes that the Department of Health is developing a workforce strategy for social care, and she gives more detail on those matters in her statement. 10:03 10:03

Moving then to the second statement, that is of Dr. Marina Lupari, who is the Director of Independent Health and Care Providers, IHCP. Dr. Lupari provided a statement on 26th February 2024, and that has the Inquiry reference STM-209. 10:04

Dr. Lupari explains that the IHCP is a membership organisation representing private not-for-profit charity and church affiliated organisations, providing residential and nursing home care, sheltered housing, daycare, and care in the home. Dr. Lupari states that 10:04

IHCP did not have a role in the process of resettling patients from MAH. She further explains that no training resources were made available to IHCP by the Department of Health or the Belfast Trust.

10:05

Dr. Lupari does state that she represented IHCP in the commissioned review of resettlement, which was undertaken by Bria Mongan and Ian Sutherland, and IHCP facilitated a focus group to provide a response from IHCP members, and we'll hear more about that review tomorrow when we hear from Ms. Mongan and Mr. Sutherland.

10:05

Third then, Dr. Alan Stout, provided a statement on behalf of the Northern Ireland General Practice Committee, NIGPC, dated 26th March 2024, and it has Inquiry reference STM-218.

10:05

Dr. Stout explains that he is the Chair of the NIGPC, having held that position since September 2018. He explains that the NIGPC is a standing committee of the British Medical Association, the BMA, which is the trade union and professional body for doctors in the United Kingdom, and that NIGPC represents all general practitioners working in Northern Ireland.

10:05

10:06

Dr. Stout's statement confirms that NIGPC did not play a role in the process of resettling patients from MAH, and does play a role in the commissioning and quality

monitoring of learning disability services. Dr. Stout confirms that as far as he is aware the NIGPC was not aware of any concerns about the quality of care or level of medication provided to patients at MAH. He further confirms that the NIGPC was not aware of any concerns about neglect experienced by patients discharged from MAH, nor was it aware of any parents of patients in MAH seeking help to treat stress or depression arising out from concerns about how their child was being cared for at MAH. 10:06

Then finally in terms of summaries I want to move on to Ms. Newbury's statement. Elma Newbury MBE is the Interim Regional Services Director in the Northern Ireland Housing Executive, and as I've already said, Ms. Newbury's statement and exhibits are extensive, running to 195 pages. 10:07

In her statement Ms. Newbury explains that NIHE contributed to the delivery of resettlement of patients from MAH through the exercise of three of its functions. 10:07

CHAIRPERSON: Can you just take this a little bit slower just because CPs haven't read it or seen it.

MS. KILEY: Certainly. So the first function, Chair, was the delivery of the Supporting People Programme on behalf of its sponsoring department, which was the Department For Communities. 10:07

In that respect Ms. Newbury explains that the Supporting People Programme which commenced across the UK in 2003 is a revenue grant fund for third party provider organisations to provide housing related support services.

She further states that often services which are identified will also require capital funding to enable new build acquisition of a build or major work. That would entail consideration by NIHE's Development Programme Group, which manages social housing development on behalf of the Department for Communities, and Ms. Newbury's statement explains the detailed commissioning arrangements for the Supporting People Programme and how they have changed across the timeframe within the Inquiry's Terms of Reference.

Ms. Newbury explains that it is not within the legislative remit or practice of the Supporting People Programme for the Housing Executive to conduct assessments of individual support or care needs, and the Housing Executive has no role in the health assessment or referral panels to services. And, again, that is detailed further in Ms. Newbury's statement.

The second function then that Ms. Newbury refers to is the Development Programme Group. She explains that the Northern Ireland Housing Executive has been responsible for the management of that programme and budget on

behalf of the Department for Communities since 2007/2008.

The Social Housing Development Programme delivers the development of general needs social housing as it is allocated to customers who have special and specific support needs.

Ms. Newbury then explains that NIHE representatives from both the Supporting People Programme and the Development Programme Group were involved in the regional learning disability operational group, which was set up by the Department of Health and the Health and Social Care Board, which operated between September 2019 and early 2021. 10:09

Ms. Newbury goes on to explain that a representative from the NIHE Supporting People Team attended the Community Integration Programme, CIP, from 2022, that programme having been initiated in 2011 by the Health and Social Care Board to progress resettlement from long-stay hospitals, including MAH. And, again, further detail on that function is provided in the statement. 10:10

And the third function which Ms. Newbury refers to is the NIHE's assessment and allocation of social housing to Applicants pursuant to the NIHE's Housing Selection Scheme which was introduced in the year 2000.

Ms. Newbury explains that supported housing is for those who require extra housing support or an element of care in addition to a home, and they are referred to as applicants with complex needs. 10:10

Ms. Newbury explains that the NIHE Housing Support Officer ensures that applicants with complex needs are recorded on the appropriate housing list and also provide a liaison role with health trusts. She 10:11 explains that where a health trust's agreed option is for supported housing, the applicant's name will be registered on the common selection scheme for each suitable complex needs scheme. When deciding which scheme is suitable, the type of scheme and the 10:11 available care and support services provided are taken into account, as is the likelihood of a vacancy arising within a reasonable period of time. Once a vacancy arises from in an identified scheme, the relevant housing association and its joint management partner 10:11 will determine if that vacancy is suitable for the applicant at that time.

Ms. Newbury goes on to confirm that the Housing Executive has not found evidence that it had input into 10:11 the setting of targets regarding the resettlement of patients from MAH.

Ms. Newbury describes the following as key challenges

in target attainment:

"(a) appropriate alignment of supported housing capital funding, supported people revenue funding, and health and social care revenue funding towards the achievement of targets;
(b) timescales for the identification and suitable sites, longer lead-in times, late confirmation of the housing association provider;
(c) a change in approach from Trusts with increasing preferences for the use of existing satisfactory or "off the shelf" solutions."

This, she said, had a material consequential impact on budget spend:

"(d) reduced need or shift in requirements or withdrawal of need;
(e) difficulty in identifying and acquiring sites in suitable locations, agreeing the suitable design solution, planning issues, objections, community opposition;
(f) financial viability issues due to the necessity to align various revenue streams and;
(g) issues with Trust acceptance of a final quarter receipt and inability to acquire the site at the end of the programme year."

And as I've already said, Chair, that final statement

will be made available in full to Core Participants and publicised this afternoon or tomorrow. All of the other statements, including those I've just summarised and those of the witnesses to be called, are available in full already on the Inquiry website.

So with that introduction given, the first witness in this module, Ms. Rowan, can be called.

CHAIRPERSON: Okay. Let's get her in.

MS. KILEY: Ms. Rowan's statement, while we wait for her, has the Inquiry reference STM-278.

MS. FIONA ROWAN, HAVING AFFIRMED, WAS EXAMINED BY MS. KILEY AS FOLLOWS:

CHAIRPERSON: Ms. Rowan, good morning.

A. Good morning.

CHAIRPERSON: Welcome to the Inquiry. Thank you very much for your statement. It is obviously quite lengthy, including the report. And thank you for coming along to give your time this morning. So I'll hand you over to Ms. Kiley.

1 Q. MS. KILEY: Good morning, Ms. Rowan. We met just briefly. As you know, I am Denise Kiley, I'm one of the Inquiry counsel team, and I'll be taking you through your evidence this morning. You can see your statement just come up on screen in front of you, and you have made a statement to the Inquiry which is dated 12th June 2024, and it has been given the Inquiry

reference you can see at the top of the page there at 278.

You can see it on the screen, but I think you have a hard copy of the statement in front of you? 10:15

A. Yes.

2 Q. Is that right?

A. I do.

3 Q. And your statement has three exhibits also, and you have hard copies of those, do you? Okay. As we go 10:15 through your evidence today I'll call up portions of your statement and exhibits, if I want to refer you to them, so you can see those on the screen or you can follow along in your hard copy, whichever you prefer. But the first thing that I want to ask you is whether 10:15 you wish to adopt your statement as your evidence to the Inquiry today?

A. Yes, I do. Thank you.

4 Q. Okay. So in the start of your statement you give some information about your role and experience, so I just 10:16 want to look at that and ask you a little bit more about that.

At paragraph 1 of your statement you explain that you're a qualified social worker, and at paragraph 2 you go on to explain that from September 2019 to June 10:16 2020 you held the position of Senior Improvement Lead, which was a temporary post, initially for six months, in learning disability in the Belfast Trust. And in respect of that post, Ms. Rowan, was it a new post

whenever you started it in September 2019 or had someone held it before?

A. No, my understanding was that it was a new post to focus on supporting the hospital.

Q. And do you know why it was created or felt necessary at that particular time? 10:16

A. No, I'm afraid I would be making an assumption on that.

Q. But whenever you were introduced to the post you weren't given an explanation about why it was particularly created at that particular time? 10:17

A. I was aware at that particular time that there would have been I suppose a need to focus on what was happening in the hospital, and that included supporting the management of the hospital, and the running of the hospital, and then the resettlement, and that included the resettlement of patients. 10:17

Q. What were you told about the purpose of the role initially?

A. There was two -- there was one post that was advertised, and both myself and another member of staff from mental health applied for the two posts, and during that interview there was discussions about resettlement, and it was then agreed that I would do a focus -- or at the end of that it was agreed that I would bring a focus on the resettlement aspect and the other individual would be focussing on the management side of the hospital. 10:17 10:18

Q. Okay. Was your post based at Muckamore Abbey Hospital?

A. My post was part of the community services. So while

I spent time up at Muckamore and I sort of based myself for the first couple of months up in Muckamore, my role was actually managed through the community side, which is Belfast.

9 Q. Yes. 10:18

A. Yes.

10 Q. At the end of paragraph 2 you say that it was agreed that your role would be to focus on the resettlement process and:

10:18

"I would provide information to the senior management."

Can you explain a little bit more about what you were asked to do?

A. There had been a couple of unsuccessful placements, and then there was a drive in order to help support people to be patients to be discharged from the hospital. So I was asked to work on improving the discharge processes from the hospital. I think one of my first comments in relation to that was that I would be able to support, identify, what some of the issues were. I did declare at that stage that I would be hesitant as to whether I would be able to maximise discharges, but I would certainly support identifying and assess where some of the areas or the challenges were. 10:18 10:19 10:19

11 Q. Why were you hesitant about maximising discharges?

A. On the basis that, and this is possibly picked up later, but on the basis that I had worked for many years in resettlement in mental health services

and what I could do is assure that I would get an understanding of what was happening. That doesn't necessarily mean you can assure ongoing discharges at the kind of pace I think that was being hoped for at that stage. 10:20

12 Q. Was your role to be more of taking an overview of the resettlement of patients rather than be directly involved of the resettlement of individual patients then?

A. Well, my role was very much to have an overview. 10:20
I would have been involved directly with a number of patients, because that helped me understand what was happening and where we could make improvements. So, yes, I did involve myself in some of the aspects operationally. 10:21

DR. MAXWELL: Were you the named key worker for any of the patients?

A. No. No.

DR. MAXWELL: So there was a social worker who was the principal key worker for the resettlement? 10:21

A. There was -- sorry, ask me that again?

DR. MAXWELL: So I'm assuming, and maybe I'm wrong, that there's one person who is responsible for each individual patient?

A. Yes. 10:21

DR. MAXWELL: And you weren't that key person for any patient?

A. No. No.

DR. MAXWELL: But you were involved, but you weren't

the key worker on the resettlement for any of the patients?

A. No. Absolutely, no. But I would have joined some of the discharge planning meetings.

DR. MAXWELL: Yeah. No, I understand.

A. Meeting with families, meeting with patients, just so that I understood and got feedback and spoke to people, yeah.

DR. MAXWELL: Yeah. Thank you.

13 Q. MS. KILEY: You referred there briefly to your previous experience in mental health, and did you have experience then in resettling patients from mental health services to the community. 10:21

A. Yes. I would have done that over about a ten year period in mental health services. We closed three wards, it was up on the Knockbracken site, and we closed three wards, including a brain injury ward. So there was a lot of complexity involved in those discharges. So I had a detailed understanding of the work required within both the trust with families, with providers, and also in terms of the community infrastructure that's required to support resettlement, because for me resettlement is a mixture of, you've got a complex discharge, but you also need to have the community supports to transition people out of hospital and then maintain them safely. So it is, the actual discharge point is just part of a journey for me, and a lot of the very intensive work can happen post discharge. So I would be familiar with that process, 10:22 10:22 10:22

yes.

14 Q. Did you have any particular previous experience in the learning disability field?

A. Yes, I'd worked -- I began my career in learning disability. So I think probably about my first decade that I worked in community side of learning disability, which was supported housing, residential, flooding support services. 10:23

15 Q. Is that in your role as a social worker?

A. No, I wasn't qualified at that point. So that was in social care roles. And when I qualified I did a placement in mental health services, and that's when I moved over to work in mental health. 10:23

16 Q. And in your statement, if we scroll down to paragraph 5 then, please, you explain that in the period that you were in post you prepared 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, and this was in light of a number of unsuccessful trial placements, and you list the exhibits, the reports which are exhibited to your statement there. 10:23 10:24

The first is "Proposals to address the barriers to resettlement of MAH patients", which is at Exhibit 1. Then a document entitled "Transition team proposal", which is dated February 2020, and is at Exhibit 2 of your statement, and then "Summary of learning from unsuccessful trial placements", June 2020, which is 10:24

Exhibit 3.

And in fact there is a further document exhibited within your statement which is the "Homes Not Hospitals" presentation; isn't that right? So we'll come on to look at all of those things in due course. But first of all before we move on to look at the reports that you prepared, I want to ask you a little bit more about what the process of resettlement was like and what you encountered whenever you were first appointed, and you explain a little bit about this at paragraph 22 of your statement, if we could go to that please? 10:24 10:25

We can see there that you say: 10:25

"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." 10:25

Can you explain a little bit more about the role of the community services in resettlement? I know it is in your exhibits which we will come to, but if you had to summarise that role, how would you do that? 10:26

A. Well, I suppose a community team is maybe what you would describe as a generic community service. So they work nine to five Monday to Friday. They would

comprise of an Assistant Service Manager, a team lead, and a group of either a social work or multidisciplinary staff, including nursing, OT, etc. They would have caseloads, which are in one of the documents, so the caseloads give you sort of a better idea in relation to the staff would be managing 30 to 40 cases at least on their caseload, and as resettlement had continued, because there had been several hundred people discharged I believe by this point, those teams were also managing an amount of complexity in the community from people who had already been discharged. 10:26 10:27

The community social work and nursing teams then would have linked to care management. So the care management dealt with commissioned side. So they would have had a similar structure, they would have had a team lead and an Assistant Service Manager, and they would have been involved in the placements and the care that somebody would have. So anything that was being commissioned or purchased would have been organised through that side. So things like domiciliary care, supported accommodation, nursing or residential care, if somebody was going into that type of placement or care, then they would have been involved with that aspect. So you needed those two aspects together for anybody that was being discharged from Muckamore. 10:27 10:27 10:27

17 Q. And is there another aspect? You referred also to working in partnership with hospital staff, were

hospital ward staff involved in the process too?

A. In relation to resettling?

18 Q. Yes.

A. Yes. No, hospital staff were integral, because they would have been providing support for inreach from providers coming in, they would have been involved in the discharge planning, sharing information in relation to sort of the history and the knowledge, and how people, how the patients have lived, and what some of their likes and dislikes and things would be on the ward level. So they would have fed into any discharge planning. And then in some cases they also would have been involved in providing outreach activities. So they were, you know, all these different participants were absolutely vital in an effective discharge. 10:28

19 Q. And whenever you commenced in post, was there a single document that explained the process of resettlement and the role that each of those participants played?

A. Not that I'm aware of, no.

20 Q. So how then, for example, would hospital staff have known what their responsibilities and duties were in respect of resettlement? 10:29

A. Well, I suppose when I went in 2019, what I could see was that, you know, this was something that staff had been doing for many years. Hospital discharge is a routine feature of working both in hospital and community side. So I suppose one of -- it was more that the complexity and things that were happening in 2019/2020 that was leading to some of the unsuccessful 10:29

discharges.

21 Q. And what about families? Was there a document or some guidance that communicated to families what the process of resettlement would be like?

A. Again, not that I was aware of at the time. Now I know there was individual pieces of work, there was guidance on inreach and outreach, so there were a couple of documents in the system. But if -- there wasn't one piece of work. But I believe something was developed in 2021. 10:30

22 Q. In 2021, are you referring to something being developed specifically to explain to families what the process was?

A. No, it was mentioned in the question I was asked.

23 Q. This is in one of your questions. 10:30

A. Yes.

24 Q. Yes, there is a document that the Inquiry has seen as part of the Evidence Modules, and I think you were asked a question about it, but you were unable to answer it, you're not familiar with the particular document; is that right? 10:30

A. No. And it happened after I left.

25 Q. Okay. But just focussing at the time that you arrived then, if there wasn't a particular document then explaining to families what was going to happen, how then would you have expected them to know what the resettlement process would entail? 10:31

A. The resettlement process was discussed with families at the ward discharge meetings, and I suppose one of the

aspects for me was, and one of the reasons why I was suggesting a resettlement or transition team, would have been to increase the amount of communication with families so that we could improve that.

26 Q. And we'll come on to look at that. I just want to keep focused on what was in place at the time that you commenced post, and in paragraph 23 you say that whenever you took up post there was a community integration coordinator post. 10:31

10:31

"This person provided the link between the hospital and community services with a regional coordination role and reported to Belfast Trust community services and the HSCB on discharges. They were managed through the service manager for the community teams." 10:32

A. That's correct.

27 Q. Can you explain that a little bit more in summary form what the functions of the community integration coordinator was? 10:32

A. That individual, when I arrived, had been holding the -- I suppose what you would describe or what was described as the primary target list, so the resettlement list, with the proposed plans for patients. They would have linked in with each of the Trusts, because obviously Muckamore had that difference because it was a regional setting. Then you were working across a couple of different Trusts. So their role was part Belfast, but then also part 10:32

communication, and linking the different Trusts in with the wards, or addressing any issues or concerns or things that might have come up.

28 Q. And the resettlement list, you've referred to that in your statement too. Is that just what it sounds like, a list of patients that were to be resettled from Muckamore Abbey Hospital? 10:33

A. Well, to be fair, it was essentially all the patients. So, yes.

DR. MAXWELL: We've heard evidence about something called a priority, a PTL. 10:33

A. PTL, yes.

DR. MAXWELL: Is this the same as the PTL? Which I think originated way back in 2006/2007.

A. Yeah. 10:33

DR. MAXWELL: So some patients might have been on it since 2006.

A. Potentially. I couldn't tell how long patients had been on it. I was very familiar with the -- it was the same process in mental health, we had a PTL list and we worked to that. I suppose the difference with Muckamore was, everybody that was on site was being considered. 10:33

DR. MAXWELL: So the title implies that the people at the top would be the highest priority. Is that true, or was everybody on the list of equal priority? 10:34

A. Everybody on the list had equal priority. It was really just more -- from my view at the time, it was who might be able to be matched with whatever service

was out or available.

DR. MAXWELL: So presumably some people were on the list and got discharged after a shorter period of time on the list?

A. Yes. 10:34

DR. MAXWELL: And some people, as we've heard, potentially even they're still there now, have been on the list since 2006/2007.

A. Yes.

DR. MAXWELL: So when you're looking at this list -- 10:34
well, I'm wondering what the function of the list is? And then, secondly, how is a person in this list chosen for intensive work to try and resettle them?

A. It's more about what's available. So if there is something available that might suit an individual's 10:35
needs, then you know that you'll be able to follow -- I'm not going to say smoother discharge process, but you know, you know that that's a discharge that is achievable.

DR. MAXWELL: So is the starting point 'this is what's 10:35
available, which patients might it suit?', rather than 'this is what this patient needs, let's go and find something that's bespoke for them'?

A. I would say there was a crossover, but you couldn't say it was entirely one or the other, because there were 10:35
services being developed to meet people's needs. But one of the issues then that I was encountering was, you know, the depth of that assessment, and how detailed that assessment was and, therefore, that would impact

what was being proposed for some of those individuals.
DR. MAXWELL: So the people who have been on the list since 2007, is it that there was just not anything being developed that met their needs?
A. I couldn't -- because there wasn't a date on it as to how, you know -- so I couldn't see a priority in terms of 'Well this person has been here the longest length of time', it may also be feedback from the ward that somebody was absolutely ready to move on, and you'd also still be getting admissions in up to a point, until they stopped. And, again, if somebody was a recent admission in, you'd be hoping that, and working towards getting that person potentially back out of hospital again, before they got into that sort of longer stay situation. 10:36 10:36 10:37
DR. MAXWELL: So would they have been a higher priority? Would it have been a higher priority to try and get recent admissions out sooner than the longer stay patients?
A. Well, I don't know that they would have been put ahead. You know, you were discharging a number of people every year at the same time, but certainly I, if I was looking at it, I would be looking to see, you know, is there an opportunity to have this person go back to where they were, or what could we do to get this individual? 10:37 10:37
DR. MAXWELL: Sorry, I will stop in a minute. What was the purpose of this list? If everybody was on it and it didn't give you any indication of who was next in

line, why was there a list and who was it being reported to?

A. The list was RAG rated.

DR. MAXWELL: Oh right.

A. Which then you would have plans against some of the individuals, and then what I was finding was that some of those plans were possibly not as robust, at which point I would be rating that person as, or that plan, as a concern. 10:37

DR. MAXWELL: And who was reviewing, from a governance point of view, this list? 10:38

A. The list would have been known to the director. It would have been the focus of the meetings.

DR. MAXWELL: The Directorate Director?

A. Yes. 10:38

DR. MAXWELL: Not the Board Directors.

A. No, the Trust Director.

DR. MAXWELL: So "director" is a word that's used a lot.

A. Okay. 10:38

DR. MAXWELL: So do you mean the person at the Adult, Social and Primary Care Directorate, or do you mean somebody who sits on the Trust Board?

A. Oh, adult, social and primary care.

DR. MAXWELL: At the directorate level? 10:38

A. Yes. And also that was the focus of the conversations with the Health and Social Care Board. So we had a monthly meeting, and we also used the list with the other Trusts, so all Trusts would have been involved in

that monthly discussion, and we would have gone through each individual on the primary target list.

DR. MAXWELL: So the Directorate, the HSCB, the commissioning Trust for the patient.

A. Yes. 10:39

DR. MAXWELL: Would, on a monthly basis, see this list and the RAG rating.

A. Yes.

DR. MAXWELL: Okay. Thank you.

CHAIRPERSON: And can I -- 10:39

PROFESSOR MURPHY: Before we leave -- sorry.

CHAIRPERSON: Sorry.

PROFESSOR MURPHY: Before we leave lists, we've heard from other witnesses that there was a second list, the delay discharge list. Did that exist when you were 10:39 there or did that come after you had left?

A. I'm going to suggest most of the people on that list were effectively delayed discharges. So it may just be people's terminology around the list. The only second list that I was involved in, and it wasn't so much a 10:39 second list because the information would have been on the main list as well, was that I created an escalation list of people where I felt we did not have robust plans for, because I wanted to get that escalated and identify the numbers of people that we were potentially 10:40 looking at, because I felt there was potentially a perception that there was somewhere identified for everybody, and I wanted to make it clear that we did not have that assurance.

CHAIRPERSON: And then can I have a go.

A. Yes.

CHAIRPERSON: We know there were lots of targets set, political targets and presumably management targets in terms of resettling all the patients from Muckamore. So when you came into it, there was effectively a list of everybody who needed resettling, and you say it was RAG rated, but how was it RAG rated? What were the red alerts, as it were? Those who had been there longest, or those who it was most difficult to place, or for those for whom you had no plan? How was it assessed? 10:40 10:41

A. Yeah, the -- the last one that you were suggesting. So it would be complexity and where there was issues with a plan, or that a plan was potentially a couple of years away, as opposed to how long somebody had been in hospital or... 10:41

CHAIRPERSON: Right. Although complexity and how long they had been in hospital may go hand in hand.

A. May go hand in hand. And that's why it's difficult just to give you 100% on any specific... 10:41

CHAIRPERSON: No, I wholly understand that. But if your RAG rating starts with those who are most complex, it doesn't sound as if there's then an intense focus on creating a custom built resettlement place for that individual? You're still looking at, 'Well, what is their house in the community and what can we adapt for the individuals that we've got on our list?' - is that unfair? 10:41

A. When I, I suppose I was there for a limited time.

CHAIRPERSON: Sure.

A. So I kind of arrived when there was lots of plans had been done. So I know for some individuals that some bespoke plans were being looked at. Some other plans were linked to the development and building of new supported accommodation. Some plans were linked to the opening of nursing care. So there was a whole -- the entire range of options were there. 10:42

CHAIRPERSON: Okay. So your RAG rating did have a purpose, as it were. 10:42

A. Yes. Yes. Yeah. No, to RAG rate it made sense because for me there was maybe not enough clarity as to, that there were not robust plans for some individuals.

CHAIRPERSON: Yes. 10:43

A. And that needed to be known and addressed, because when you take into account planning something can take anywhere from one to three years, even from a mental health resettlement, there was one or two individuals that literally took us years and years to get something realistic for them in place. 10:43

CHAIRPERSON: Yes.

DR. MAXWELL: Would it be fair to say that the RAG rating was not on the complexity of the provision but the risk that it might not come to fruition? 10:43

A. On the basis that those two things are fairly well linked.

DR. MAXWELL: Yes. So you could have a complex plan that you thought ti was robust and you thought it was

definitely going to happen, and that would be green. And then you could have somebody else where the stars had to align and you were less confident that the stars would all align.

A. Yes. Or that there was a plan attached that you were concerned may not come to fruition, because that's another possibility. 10:44

DR. MAXWELL: Yes.

A. Yeah.

CHAIRPERSON: Thank you. 10:44

29 Q. MS. KILEY: I want to return to the personnel involved in the process whenever you took up post. You referred there to the Community Integration Coordinator, which we have discussed. But in your statement at paragraph 16 you also refer to the "Trust Planner". So if we can turn to paragraph 16, please, you refer to the Trust Planner, Maurice O'Kane, who was in post in 2019: 10:44

"...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 was followed by mental health services resettlement. I am unable to recall exactly when the planner went on long-term leave in 2020, and then retired and the post remained vacant when I left in June 2020." 10:44 10:45

Can you say anything more about the role that the Trust Planner had and where that sat with the other participants that you've described in the resettlement process?

A. The role sat slightly outside or offset from the community services, but absolutely linked in. The role was entirely reliant on information from community services in order to impact and provide the information for planning. The planner then was the link with the Northern Ireland Housing Executive, with the supporting people, Health and Social Care Board would have sat on the Belfast Area Support People Partnership, and also had that business planning role, because any of the supported accommodation, those lead-in times you were potentially looking, as you were describing earlier, the capital funding potentially for something and then the ongoing supporting people funding. So it was an absolutely crucial and supportive role to community services and for discharge planning, particularly for the supported housing schemes and, you know, learning disability had developed a lot, a good number of supportive housing schemes previously, and it was the same process in mental health services. So it had worked very effectively.

10:45

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DR. MAXWELL: And where -- this was an estates planner? This was somebody who was planning the physical estate but not the care provision?

A. Yes, basically, yeah. Though he wasn't working in estates as such, he sat as a director.

DR. MAXWELL: Yeah, but he was planner.

A. Yeah.

DR. MAXWELL: Who was saying either we need to chat this, or build this here. 'Talk to the architects, here's the plan' -- 10:47

A. Coordinated.

DR. MAXWELL: And talking to the Housing Executive about that whole estate thing, yes.

A. Yes.

DR. MAXWELL: Thanks. 10:47

30 Q. MS. KILEY: Did you say there he sat to the director -- he reported to the director; is that right?

A. Yes.

31 Q. Yes.

DR. MAXWELL: Director of what? 10:47

A. Adult Community and Older People Services.

DR. MAXWELL: Okay.

A. And I think he was also linked in to performance and planning within the Trust as well.

20 32 Q. MS. KILEY: So is it right then to say that the Trust 10:47
Planner role wasn't an exclusively Muckamore based role, there were other functions in respect of -- that the planner had?

A. He, as far as I'm aware, he worked across Mental Health and Learning Disability Services. But he had worked 10:47
extensively through resettlement. And that had been my experience with him.

33 Q. You said there he was in post whenever you commenced in 2019, but you describe a period that he went on

long-term leave in 2020, and then the post remained vacant whenever you left in June 2020. Did anyone take on the responsibilities of the Trust Planner whenever he left?

A. No. 10:48

34 Q. And so --

A. Well, not that I'm aware of.

35 Q. Yes. And you were in post at the time. What effect then did the absence of the Trust Planner have on the progress of resettlement? 10:48

A. It was the -- well, it impacted the business cases. So the business cases that were sitting, there's only -- there was July and December were dates when the business cases -- they had to go through a particular process within the Trust, within the Housing Executive, 10:48 these were very detailed, had financial planning aspects to them, and if you missed a date, and I think that was my concern sort of approaching, because I knew there was a date in July, and if some of those plans didn't go through July well then the next opportunity 10:49 to put plans through was going to be December 2020.

36 Q. So there were particular dates which business cases for identifying potential placements had to be submitted by, is that right?

A. Yes. Yes. 10:49

37 Q. And that was one of the Trust Planner's responsibilities, is that right?

A. Yes.

38 Q. So are you saying that then those business cases were

unable to progress whenever the Trust Planner wasn't in post?

A. Yes. At that time. When I was there. I can't say for anything after that. I suppose the other, as you'll be well aware, the lockdowns and pandemic, et cetera, had started at that stage, so that was a difficult couple of months anyway. 10:49

39 Q. But the inability to progress business cases was presumably a significant barrier in the resettlement process? 10:50

A. For me I knew it was going to slow things down, because if you couldn't continue with planning, you were pushing something being built or being moved on for whatever length of time it took to get that initial planning stage completed. 10:50

DR. MAXWELL: So you said earlier that he reported to the Planning and Performance Directorate corporately. Are you sure that nobody from that division was taking forward the business cases?

A. I'm not sure if they were. 10:50

DR. MAXWELL: So that's something we'd have to check with the Trust?

A. I didn't have sight of it.

DR. MAXWELL: Yes. No, fair enough.

A. Yeah. 10:50

CHAIRPERSON: Sorry, did you liaise with that individual when he was in the role?

A. Did?

CHAIRPERSON: You liaise with that --

A. I liaise? Yes. No, absolutely. I would have gone to --

CHAIRPERSON: Right. Well when he had left, was there anyone left for you to liaise with?

A. Was there anybody to liaise with when he left? 10:50

CHAIRPERSON: Yes.

A. Not -- no, I didn't have.

CHAIRPERSON: Right. So, so far as you were concerned, that was a bit of a gaping hole?

A. Yes. 10:51

DR. MAXWELL: But there was only a few months between him leaving and you leaving in 2020.

A. I don't know exactly what date he left in.

DR. MAXWELL: Okay.

A. And obviously he would -- he was off unwell before he 10:51 went permanently.

DR. MAXWELL: Okay.

A. And I -- it was one of my last emails was to flag my concerns about what would be happening with the support accommodation, because if that plan doesn't continue, 10:51 I know that you're pushing things by at least six months.

PROFESSOR MURPHY: Well what I don't understand, given that he'd left, is that they didn't extend your post? Because then you were another major cog in the wheel 10:51 that was gone.

A. Okay. I'm unable to -- I didn't get advised as to why.

DR. MAXWELL: Is it possible that yours was always going to be a short-term post to assess the situation,

because you weren't the key worker for any of the patients, was it that they never intended it for your post to be permanent?

A. And in terms of resettlement I would never have expected it to be a long-term permanent post, because re-resettlement in itself is finite, and I would have done it within mental health services to a point, but then you continued in your role as assistant service manager, or service manager, or whatever it is that you were doing. So... 10:52

PROFESSOR MURPHY: But there was still quite a lot of people to be resettled. It was not as though the job was finished?

A. Yes.

40 Q. MS. KILEY: And you had also made recommendations in a number of the papers that you had presented, and did you feel whenever you left post that the recommendations that you had made were completed and your work had then been exhausted? 10:52

A. Ehm, well certainly we'd got some headway with the transition, some staff to work on resettlement side. I would have liked us to have done more. Certainly I think we'd sort of got -- we'd made some headway. The significant -- the review of the Serious Adverse Incident or the SEAs was work that I'd pulled together -- we'd starting changing some things or making improvements on the basis of what we were learning as we were going along, but I think we felt there was a lot more that we could do with that. 10:53 10:53

41 Q. And that work itself was dated June 2020; isn't that right, and we'll come on to look at that?

A. Yes. But there was -- we were learning on the way, because obviously those unsuccessful placements had been happening over a period of time, so I was reviewing ones that had happened before I was in post and then ones that happened just as I arrived in, in that first couple of months as I started to assess what some of the challenges and what some of the issues might be, and then it was a matter of trying to get that learning into the system. So we did things like, we improved the assessment forms and checks for inreach and outreach so there was lots of things that we could do as we went to make those adjustments and improvements, but again it was something that I felt we could do a lot more with, which was the purpose of doing the review in the first place, so that people would have it in one document. 10:54 10:54 10:54

42 Q. Yes. And we will come on to look at it, but whenever you were told that the post wasn't being extended, were you making the point that there is more work to be done? 10:55

A. Yes.

43 Q. And what response were you getting to that?

A. I just wasn't given, and I can't say anything more than that because I actually wasn't given an answer. I was actually disappointed because I felt we had a good opportunity to continue with pieces of work and that we had got some improvement underway. But that was just a 10:55

personal view.

44 Q. Okay. I want to go on then and look at some of the challenges that you identified. You explain these in your statement and then you make reference to your exhibits, which were also looking at the barriers to resettlement. Can we go to paragraph 25 of the statement, please? You say there that: 10:55

"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 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 coproduction with family and carers. The community teams advised they were unable to provide that level of work." 10:56 10:56

Can you explain a little bit more about what person-centred planning is? 10:56

A. Well, person-centred planning is, I suppose if I describe it that the community teams, I've mentioned about their caseload sizes. So they've got what would be relatively normal caseload sizes. So whenever you want to do much more complex work with somebody, that's very time intensive, and the Essential Lifestyle Planning is effectively just one of the tools. So there's a range of tools you could use, but Essential 10:57

Lifestyle Planning is probably the most common one within learning disability services. When I had previously worked in learning disability services we had used it, and it's very much about bringing together the individual, and the family, and having conversations into that very granular detail of what people's likes, dislikes, what makes a good day for them, the very -- the things that are positive, the things that they really don't like in their lives, and it's that level of detail that really can improve somebody's journey and experience on a day-to-day basis, and about trying to transfer that from a hospital setting to a community setting. And it's also about relationship building. So you are getting to know a person much better, their family much better, and you're just opening up really healthy communication channels. And it was difficult for the community teams at that time to consider doing that type of really detailed work, which was what I was hoping that the resettlement team -- and we did start doing some Essential Lifestyle Plans, and one of the other Trusts, the South Eastern Trust, had an essential lifestyle planner, which I've mentioned.

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10:58

45 Q. Yes, you refer to that later in your statement?

A. In the transition team work, yeah. So they had had somebody working on that model for several years with a number of the patients.

10:58

46 Q. At that early stage were you given any explanation as to why it wasn't being used?

A. No, the -- I suppose I initially assumed it was in place, and then I realised -- because I had previously worked in learning disability community services, and it was something that was sort of seen as good practice, and then I realised that wasn't taking place. So -- and then I spoke with the service manager and assistant service managers to see was that possible, and the feedback was that they didn't have the capacity to do that type of work.

10:59

47 Q. So was it a resources thing? When you say "capacity", was it that the community team had heavy caseloads which you have referred to?

10:59

A. Yes.

48 Q. And so didn't have the resources to take on that time intensive work?

10:59

A. Yes. And it was unreasonable then to ask or expect them to do that.

49 Q. And you have referred there to the transition team which you had hoped to get in place. So you had hoped, and I think you said there that the transition team would start doing that sort of work. You refer to the transition team at paragraph 32. If we can turn to that now and to your exhibit. You say that the team is described as a resettlement team and a transition team at different places of your statement, but is that the same team?

11:00

11:00

A. It is the same team.

50 Q. It's the same thing. And you had said that, you say there halfway down:

"I believe 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 coproduction. Details of these are contained within Exhibits 2 and 4." 11:00 11:01

You then -- that is something which is addressed in a number of your exhibits. The first one is "Proposals to address barriers to resettlement of MAH patients". So if we could bring that up, please, at STM 278-25? And we can see there that the title is "Proposals to address barriers to resettlement of MAH patients to be tabled for consideration by MDAG". 11:01

So you prepared this paper. It has no date on it, can you recollect roughly whenever you prepared it? 11:01

A. I think I had this finished probably around December 2019. I think that there was movement in patients. So it was -- so December/January time 2019, early 2020. Because the MDAG was in February 2020.

51 Q. Yes. 11:02

A. And this went to inform the presentation that Marie gave to MDAG.

52 Q. Yes. So you prepared this paper. There is another one then, if we just a take an overview of them, at page --

if we can scroll down to the next exhibit? Hold on, I'll just get the page reference. I'll take you back to these, but I just want to get an overview, Ms. Rowan, of how they all link together. So the next document is page 34, which is entitled "Transition Team Proposal". So that's the second document dated February 2020. And you say in your statement that these two documents then fed in to the presentation that was made to MDAG; is that right? 11:02

A. Yes. 11:03

53 Q. If we just go forward to page 80, so we can see that. This is the presentation that was then made to MDAG. So the first two documents that we looked at then, were they essentially just preparatory work all with the purpose of feeding into the MDAG presentation? 11:03

A. When I was writing them I wasn't aware, certainly the first one, because the first one was me outlining what I was seeing as the challenges, which is what I had said to the director, that I felt was the one thing, you know, the one thing I could assure would be that I would identify what some of the issues were, and then from that point we would see what improvements we could make. So MDAG was not mentioned at that point. But then as that developed, I think Marie had mentioned about MDAG, and I went ahead also with the transition team, because I was hoping to influence and generate within the system and get support for the work that I was hoping that we would lead to. 11:03 11:04

54 Q. And so ultimately the issues that you identified in the

first paper, and then the proposal that you made in the second paper for the transition team, all were incorporated into this presentation to MDAG; isn't that right?

A. Yes. Yes. Now there's more detail -- 11:04

55 Q. Yes.

A. -- in the other two documents, which is why I thought it would be useful to show the background to the MDAG presentation.

56 Q. Yes. You didn't make the MDAG presentation; is that right? 11:05

A. No, Marie Heaney made the MDAG presentation.

57 Q. And what was the purpose of it?

A. Well, I suppose the -- well, Marie wanted to share the information with the Department in relation to where we are, an analysis of what was happening within resettlement. 11:05

58 Q. And was it intended, was it a bid essentially also for the transition team which you had identified as being proposed? 11:05

A. Yes, I believe there was an ask in it in relation to that, and it's in the presentation.

59 Q. Yes. We'll look at that and then we might go back to some of the detail in the earlier exhibits. But we have the presentation slides up at page 80. First of all there's a bit of context. Page 82, if we could scroll down to, please, gives a little bit more of an outline. 11:05

CHAIRPERSON: I'm just thinking about, before you do

that, about timing. Are you all right to go on for about ten minutes more before we take a break?

A. Yeah.

CHAIRPERSON: Okay. Just let me know if you need a break beforehand. 11:06

A. Thank you.

CHAIRPERSON: Sorry

60 Q. MS. KILEY: Thank you, Chair. Ms. Rowan, hopefully you'll see this on the screen. There's a diagram, it might be quite small, but do you -- this wasn't a 11:06 presentation which you prepared. Are you familiar with the diagram?

A. I'm familiar with the diagram because it was in the...

61 Q. It was in it?

A. Yes, it was in that. I think it was Bernie McQuillan 11:06 supported Marie Heaney with, you know, pulling the different strands of this together.

62 Q. I just wondered can you tell the Inquiry any more about what this diagram depicts? We can see there that it is titled a model, "National Service Model (NHS England 11:06 2015)". So it seems to be something that is taken from NHS resources; is that right?

A. [WITNESS NODS].

63 Q. And does it relate specifically to learning disability, do you know? 11:07

A. Oh! Ehm...

64 Q. If not, if you can't and answer that --

A. I'm just reading the top bit of it. National Service Model.

65 Q. It's "National Service Model (NHS England 2015)".
PROFESSOR MURPHY: I think it was just --
DR. MAXWELL: I think it does as well.
66 Q. MS. KILEY: And you can see in the middle at the bottom that it says: 11:07

"Person and family carers at the centre..."

And then there are a number of principles which arch around. I'm not going to ask you about all of them, 11:07 but there is one just on the left-hand side and it says:

"Principle 4L support to my family and paid staff." 11:07

And there's reference there to support and training for families and carers. Can you see that just at the first bullet point?
A. Yeah.
67 Q. And that appears to be a reference to support and 11:07 training being available for families and carers, and I wondered if that was something that you had encountered as being available in other jurisdictions?
A. Ehm, support is a key part of what a transition or resettlement team can do. Can I just say, the 11:08 different -- moving between transition and resettlement, when I worked in mental health services we called it "resettlement". Learning disability didn't seem -- services -- didn't seem so keen with the

name "resettlement" and seemed to prefer the term transition. So that's why you hear the two, but they were effectively the same.

The bit that I've found really helpful in terms of having a resettlement team is the support that is able to be -- that extra support. So I'm not saying that there wasn't support offered and discussed with families, and certainly I was at discharge meetings and there was connections with families, and there was also the carers advocate and people up working in Muckamore as well when I was there. It was just that a transition team can make more or have more opportunity to focus in on those pieces of work. Training for families and carers, I'm not sure that I've been asked that much for specific training. But if anyone had of wanted anything, then certainly they would have been able to be involved, PBS,you know, if somebody wanted access to something it certainly would have been something we would have tried to deliver on. 11:08 11:09 11:09 11:09

68 Q. But it's not something you had experience of delivering, is that what you're saying?

A. Not through resettlement, because largely you were moving to other providers providing the care, and a lot of these families had cared for individuals for many years themselves. So, you know, they had... 11:10

CHAIRPERSON: So the training isn't in supporting the resettlement, it is if the patient were, for instance, moving home?

A. Yes.

CHAIRPERSON: And then the training that might be afforded to the carers who were looking after that individual.

A. Oh, to the carers and the staff, yeah. Okay. 11:10

CHAIRPERSON: Yes.

A. No, there was -- again I'm going to take that back to having a resettlement team, because the resettlement team can provide, and certainly within mental health services absolutely provided that wraparound support to 11:10 providers. I don't know just how much of it would have been going on within learning disability services within that time, but if they were struggling to do Essential Lifestyle Plans, well then I would say it was probably limited. 11:10

69 Q. MS. KILEY: So this was the sort of thing that you would anticipate a resettlement or transition team to be able to assist with, if it was necessary. Is that what you're saying?

A. Yes. Yes. And I know psychology, certainly, where 11:11 they were able to, they were providing positive behaviour support training into providers, and were having an oversight, and would have spent time supporting placements. And then, of course, the ward staff coming out to do, you know that inreach and 11:11 outreach work with providers, that is essentially allowing people to shadow and experience. So that is a type of training.

70 Q. Okay. If we can move on.

PROFESSOR MURPHY: Could I just ask one question about the transition team, just to clarify: Were you proposing this for Belfast Trust or to be a regional resource?

A. I was trying for Belfast Trust, and we did get some resources into that. I hadn't gone as far as making it regional, but ideally regional would have been better because then you've got consistency, but you know -- and Trusts had different ways of doing things. But I felt some of the trusts had got more of a resettlement team together than potentially we had got within Belfast. So... 11:12 11:12

PROFESSOR MURPHY: Yes. Thank you.

DR. MAXWELL: Can I ask, there are a number of things in this presentation are seen as the barriers, and you talk in your statement, and sorry if you were going to come to this, about the crisis intensive support team. 11:12

A. Yes.

DR. MAXWELL: The absence of one. And you also talk about the need for Band 5 professionals to support people in the community rather than the grades that don't have a professional background. In limited resources, which we always have, did you think the transition team would be more successful than those? You know, how would you split the ply between those three different deficits? Were they all equally important or did you think the transition team would be able to compensate for the lack of an intensive support team and the lack of professionally qualified support. 11:12 11:13

A. Yeah. An intensive support team -- the community teams were only working nine to five Monday to Friday, so you've got an instant problem with 24/7 accommodation, which is all right at those initial stages when you've still got the hospital staff coming out. But when that 11:13
ends and that's handed over, or the demands on the hospital itself sometimes, certainly when I was there, was causing problems, because if they were short-staffed then they were unable to release staff out to do the support. And while it didn't half every 11:14
time, you know, there are key moments when that support is absolutely vital. So for me, if you had of had that wraparound service, you would have been able to support people and be out there to support any of those issues coming up in the community much quicker, before a 11:14
placement might disintegrate or other problems, and it generally is evenings and weekends when some of those things tend to...

DR. MAXWELL: I think in mental health services it's quite common to have a dedicated team who are not 11:14
pulled out from something else, they are the intensive support team?

A. Yes. And I'm not suggesting a resettlement team is the only way of doing this, there are other models, that just because I had worked on a resettlement team model 11:14
I knew how it could work and I knew it could improve some of the areas that were showing up to me as challenges.

DR. MAXWELL: So were you thinking that the transition

team would do a little bit of this intensive support and provide the professional support that was absent?

A. Absolutely. And I also intended that if we had of been able to draw more of that together, long-term a resettlement team can transform into that type of service, because we had done a similar transformation project at the end of resettlement with a team within mental health and you've developed a group of staff who are able to manage and support very complex individuals in placements, and those are really valuable skills to have and keep together, because when the hospital eventually goes, you do lose a lot of knowledge and skills from that setting. So it's good to have some of those people pulled out into the community. 11:15 11:15

71 Q. MS. KILEY: I think if we can bring up page 34, you have reflected much of what you have contained in your transition team proposal paper there. This is the paper dated February 2020, and you describe a proposal for a transition team, and you can see at paragraph 2: 11:16

"It's recognised that any proposal has consequences on other parts of the service as the work required would already have a significant impact on the to workload of the community LD team the redeployment of one staff member has been discussed with the head of community services." 11:16

You go on at paragraph 3 to explain there:

"The proposal of two staff as a minimum staffing level, but a well developed and robust team, would include a team lead, OT, psychology, and could potentially be used as the service for any complex discharges, leaving assessment of treatment at a more timely rate than the previous hospital discharges. The experience of staff developing this type of working would also enable them to work effectively in transition work for young people moving to adult services as demonstrated by the team." 11:17

So was it envisaged then that there would be this transition team that would help move along the resettlement process and bring in those types of tools that you had described earlier to create person-centred planning, but then after the resettlement process was complete, they would use their skills to work in the community. Is that essentially how you envisaged it? 11:17

A. Yes. Yes.

72 Q. If you scroll down to the next page, in terms of staffing proposal, I think it's fair to say it wasn't a huge team that you proposed; two community integration staff, and they are noted as managers, and then two key workers and admin to be discussed. So is that the basic team essentially with the hope that it would be developed to include psychology, OT, and those things that we've just looked at? 11:17 11:18

A. Ehm, I suppose there was concern -- the size or the scale of that, I'm recognising the concern within the system of pulling staff from other areas, and I felt if

we could get something started that -- and there was then evidence that that was working, we may have the chance to grow and develop that a bit more. I was also cognisant that we were at a certain stage in terms of resettlement. There was a small number of people, or a smaller number of people in the hospital, so it was a matter of just trying to take that scale into account. No desire to impact the community teams either, because they were already fragile as well. So it's just trying to find a balance as to what might get or have more chance of getting agreed. 11:18 11:19

73 Q. But you thought this was a good start --

A. It would have, yes. And we did get some of those posts.

74 Q. Yes. And that was after the MDAG meeting; isn't that right? So I'll come back to that. But just focusing on the posts for now. In terms of the staffing proposal there, was it proposed that all those staff would be working on Muckamore resettlements or was it a wider role? 11:19 11:19

A. No, of those posts, those would be working on, those who would be working on Muckamore resettlements, and then there was care management role as well. So I had discussions with the Assistant Service Manager -- it's in one of the other documents -- with the Assistant Service Manager about the care management aspect, because these were key workers to do the Essential Lifestyle Planning, and those pieces of work, and then you would need the care management aspect as well. 11:20

75 Q. So that's something over and above what's included in the staffing proposal there?

A. Well, I was -- it was negotiated that two identified care managers, they wouldn't join the team, but they could link in to the team, because it was easier to try and work with a couple of care managers than have that spread across a large team. 11:20

76 Q. Then whilst we're looking at this document, if we could just scroll down, please, to the next page? And on down, please, to page 37? Just pause. You can see there reference to the caseloads per key workers, and I think this is what you were referring to earlier in your evidence; is that right, that there's -- you've set out there the particular teams, and then the average caseload per key worker. So is that what you envisaged then for those staffing that we've just looked at? 11:21 11:21

A. These caseloads are the caseloads. So the community LD Belfast Trust, the average caseload per key worker -- and I need to obviously correct what I was saying earlier, because I was thinking about -- my memory was 30 to 40, but it's 40 to 60. That was information from the community services. So that was the size of the caseloads. 11:21

77 Q. That they were actually undertaking at the time? 11:21

A. That they were actually having. So that was information from them. Mental health services, because I was from there, I knew what their caseloads were approximately. And the purpose of this was to show

what the size of a caseload should look like if you want to do that sort of high intensity work with people, and you can't expect a member of staff who has got 40 to 60 people on their caseload, of which a percentage of those will be highly complex, already, to undertake some of the extensive discharge work. So that was just to show -- demonstrate the comparison. And obviously we'd done visits over, there had been communication with the East London team and, again, it was just to give examples of sort of the difference in terms of scale. 11:22 11:22

78 Q. And in terms -- I'm conscious of the time. I do want to come on to ask you more about the transition team and how it ultimately came into place, and the relationship at the MDAG meeting. I think that will take still a little bit more time, so I think that's an appropriate time for a break, Chair. 11:23

CHAIRPERSON: Well, we've been going about an hour and 25, and that's a long time for any witness, so we'll pause there. We'll take a 15-minute break and then we'll return at quarter to twelve. Thank you. 11:23

A SHORT ADJOURNMENT

THE INQUIRY RESUMED AFTER THE SHORT ADJOURNMENT AS FOLLOWS: 11:27

CHAIRPERSON: Thank you.

79 Q. MS. KILEY: Ms. Rowan, just before the break we were

looking at your proposal for a transition team as it was set out in your paper in February 2020, and what you proposed there ultimately then was proposed to MDAG in the presentation that was made in the "Homes Not Hospitals" presentation; isn't that right. So if we can turn now to look at that, please? We looked at the start of that presentation briefly earlier, but if we could turn now to page 89, please? This is the "Homes Not Hospitals" presentation that was delivered to MDAG in February 2020. And if we can just scroll out, can you see the top of that page? You can see it's entitled "Outline of Barriers to Resettlement and Belfast Trust Proposals". So this is part of the presentation that I think in fact mirrors the barriers that you had identified in the first exhibit that we looked at; isn't that right? 11:41 11:42 11:42

A. Hmm.

80 Q. So your first exhibit contained this table, and I think there are perhaps some differences, slight differences in wording, but for all intents and purposes that first exhibit that is entitled "Barriers to Resettlement" then becomes part of the presentation to MDAG; is that right? 11:42

A. Correct.

81 Q. So you can see there are a number of barriers identified. The Panel has this information and it is now published online with your statement, Ms. Rowan, so I'm not going to ask you to take us through it all in detail, but I am just going to go through briefly some 11:42

of these, and then I have some questions for you. It's quite small on the screen, but hopefully you'll be able to follow.

So the first -- the format is then, on the left-hand side a barrier is set out and on the right-hand side there is a proposal to address the barrier. So the first barrier set out there is "Community Infrastructure", and we can see there it is said that: 11:43

"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."

And you've already explained to us earlier in your evidence some of the limitations in the community teams. But if we just look at the proposals then on the right-hand column, you can see that it is proposed that there would be development of a Community Treatment and Intensive Support Services, enhancement of the positive behavioural support services in the community, and there is also there a recommendation on the third bullet point for the development of: 11:43 11:44

"... 6 bed, high level statutory Supported Accommodation (Supported Housing) for people with behaviours that challenge..."

Then the last bullet point is:

"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..."

So there are a number of proposals there to try and address the community infrastructure.

11:44

Can I ask you about the first one, the development of community treatment and intensive support services. The Inquiry has heard from other witnesses about intensive support teams in the community at various different times of the time period that the Inquiry is 11:44
looking at, which, as you know, is a wide range, but is it right then that whenever you were in post there weren't the intensive support services, is that what this means?

A. Yeah, that's correct. 11:45

82 Q. Yes. So you didn't encounter them in any of the community services?

A. No.

83 Q. And --

A. In learning disability? Yes. 11:45

84 Q. Yes, in learning disability. So this, what you were proposing here, was something new, essentially?

A. Well, it would be new to learning disability, but it's not necessarily a new concept.

85 Q. Yes.
A. Within a Trust, yes.
86 Q. But it would be -- if put in place, it was something new that would be new to patients from Muckamore Abbey Hospital in an attempt to help them in the resettlement process? 11:45
A. Yes. Yes. Or any person in the community in learning disability, it would support and potentially prevent admissions to in-patient at all for people.
87 Q. Yes. 11:45
CHAIRPERSON: And a system which had been effective in mental health.
A. Well, there's the home treatment team unscheduled care services, and at a point we had resettlement. So resettlement team. So each of those does something slightly different. Some of the problems in learning disability are not necessarily the same as in... 11:46
CHAIRPERSON: They're particular, yes.
A. As in mental health, yeah.
PROFESSOR MURPHY: But intensive support teams were well known in England, weren't they? 11:46
A. Yes.
PROFESSOR MURPHY: In learning disability.
A. Yes.
88 Q. MS. KILEY: Can I just ask you about that language. There's reference there to the community treatment and intensive support services. Is that something different than the transition team that you have been referring to, or is that one and the same? 11:46

A. There hadn't been discussions as to how those two could function together. It was difficult. Right. So there was no community treatment or intensive support team there. The transition team or resettlement team could easily have taken on that type of work, that would have been something that they could have done. 11:46

89 Q. Okay. So this is more about a function, and then there might have been discussion about who took on that function; is that right?

A. Yes. 11:47

DR. MAXWELL: But in some services, intensive support actually prevents admission.

A. Yeah, and that's what I was mentioning there, you know, the purpose of --

DR. MAXWELL: So a fully intensive support team would go beyond resettlement? 11:47

A. Absolutely. Yes. But it's great to have the resettlement skills in that team, because they have learned how to manage.

DR. MAXWELL: Yes. Yes. But going forward, if you want to maintain people in the community, never admit them in the first place, it would have to go much wider than just a transition team? 11:47

A. Yes. It's an absolute in order to keep people, and providers, and families, and people, yeah. 11:47

90 Q. MS. KILEY: If we can just scroll down then to look at the next barrier, which is titled "Independent Sector Community Infrastructure". There are a number of bullet points there, but is it fair to say that this

essentially relates to pressures that were experienced by private providers that perhaps patients from Muckamore Abbey Hospital would have been resettled to; is that right? So these are, for example community services requiring:

"...a stepped model of care ranging from Supported Housing to Learning Disability Nursing care.

Providers capacity to manage the most complex cases..."

- is listed. So is that what this is about? This is not about hospital services, this is about third party providers?

A. Yes. Yeah. And for that bit of it, it was focussing in -- it's away from the Trusts and into the independent sector. 11:48

91 Q. Yes. And we can see the proposals there about the:

"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..."

And presumably that ties in with what you have just explained. This is about when someone is in the community, giving them the supportive services to enable them to remain in the community and avoid re-admission; is that right? 11:49

A. Yes.
DR. MAXWELL: Can you explain what "All Ireland Healthcare" is?
A. Sure. It was a provider.
DR. MAXWELL: Oh, it's just the name of a provider. 11:49
A. It's just the name of a provider, yeah.
DR. MAXWELL: Okay.
A. But they had -- they were involved in planning to meet needs of some individuals with very complex care needs at a nursing level. So just to have that continuum 11:49
within the community that you can meet people's needs.
DR. MAXWELL: Yeah. Okay.
92 Q. MS. KILEY: If we scroll down again, and I'm not going to go through every bullet point, but the next is "Learning from Unsuccessful Placements", and you can 11:49
see there there's reference to a review that has been undertaken by the Belfast Trust of a number of the unsuccessful placements, and there were three common themes for improvement, and then there are a number of themes listed: 11:50

"Communication
Care Planning and Adherence to Care and Positive Behaviour Support plans
Expectation of provider and Learning Disability 11:50
Services
Community Infrastructure
Workforce both Trust and Independent Sector."

And there are a number of other issues there. You can see the fourth bullet point down, the reference again to the use of Essential Lifestyle Plans, you've already touched on some of these, but on the right-hand side we can see this is the proposal then for the transition team, and you say there that:

"The team would have the capacity to ensure the following are in place for each patient: 11:50
Essential Lifestyle Plans
Detailed Care Plans
Carers Needs Assessments
Comprehensive Discharge Planning Processes
Mental Capacity Act Assessments
Declaratory Order Completion 11:50
Structured and detailed management of in-reach and out-reach working with providers
Manage PBS support.
Comprehensive information shared with providers."

11:51

And there's reference to families and carers needing to be supported through the discharge process.

And is that the type of team and the type of functions that you experienced being carried out in the mental 11:51 health sector, or was that something that you had taken as your base and then this elaborated on?

A. No, that's what we would have worked within mental health services.

93 Q. That was it.
A. Yes.
94 Q. But did you ever get any explanation as to why that sort of team had previously existed in the mental health services area, but not in learning disability at this time? 11:51
A. Ehm, no. Sorry. I'd be making assumptions.
95 Q. But the model was one that you were familiar with and one that had been successful; isn't that right?
A. Yes. Now PBS -- just in case -- PBS wouldn't have been on the mental health side. So there's slight differences between the two, but not much. 11:51
96 Q. But it's fair to say, I think, that in proposing this you must have considered that this would be an improvement on what existed in learning disability services; isn't that right? 11:52
A. I think it also pulls the knowledge into one team, you can manage the communication more effectively, because communicating between provider, hospital, community, and the range of services that are involved, if there is one core team keeps and holds that information and is responsible for managing all the different threads, I just felt that worked well in terms of people's experience of a resettlement journey when they had that kind of support and, therefore, families and carers and people knew, and other services knew exactly where to go if there was any issues or any problems. 11:52 11:52
97 Q. And are you saying then that that sort of communication and that single point was absent then in the learning

disability services whenever you looked at them?

A. What I could see from the SEAs is that communication was constantly coming up as something, and I have it up there as the first point, communication is sort of core to an effective discharge, yes. 11:53

98 Q. Okay. And if we can scroll down then, please, to the next subheading, the next barrier, if you just pause there, is -- if we just scroll down? That's it. The next barrier. Pause. And just go to the -- so we can see the title, please. Down to page 91, please. And 11:53 pause there. The next barrier is "Timeframes required to develop community services", and you say there that:

"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."

Are you referring there to the timescales in terms of the targets for resettling patients, or are you referring to the timescales that are actually required 11:54 then to resettle a patient from the hospital into the community?

A. Well, I'm talking about the timeframe to open a new supported housing scheme, if that's what you needed for

some of the individuals. But also there was timeframes on the resettlement lists as well, which didn't necessarily marry with the supported housing scheme, the development.

99 Q. Okay. So someone's name might have been on the resettlement list and they might have been identified for a particular scheme, but are you saying that the timeframe actually for the development of that scheme then was unrealistic? 11:55

A. In a number of cases, yes. But I suppose this is probably going back to more, you know, the planning for something is incredibly important because it's going to take several years to actually achieve. 11:55

100 Q. There's reference there to the timeframe required "usually around 3 years from SOC to OBC planning". Can you just explain what those refer to? 11:55

A. That's strategic outline cases to full business cases. So that's there's -- that's the Housing Executive process in conjunction with the Trust that the planner would have been involved in. 11:56

101 Q. So is it right then to say that some -- a patient's name could have been on the resettlement list with a scheme identified as their potential place of resettlement, but if that scheme was yet to be built, it was likely that it would take around three years for that to come to fruition? 11:56

A. Yes. Absolutely.

102 Q. Was that the effect of that? And then the next barrier is "Staffing Resources across LD services (Hospital,

Community and C&V)", "C&V" being community and voluntary, is that right?

A. Yes.

103 Q. And again we can see a number of the issues that you identify, and I won't go through them all, but your proposal there is that, one of the proposals is a learning disability work force planning strategy is required, and was that across all of the services then, is that what you were proposing? 11:56

A. There was -- at the time when I was there, there was a shortage of social care staff. Now there was nursing staff, social work staff, so there were shortages right across the spectrum, and then when -- I think it's probably mentioned there somewhere, but when a new provider was opening, there was -- I saw examples where they were offering better terms and conditions in order to attract staff, and you were literally destabilising another, or a couple of other services, because they were pulling staff from other community services over into those new settings, and I think I've an example somewhere that one of the schemes was 80 staff to staff I think it was a 12-bedded scheme. So you're very labour or staff intensive and very reliant on staff, and then that was causing delays to schemes opening. So we needed something to encourage more staff into the sector, and more people to come and work in that sector. 11:56 11:57 11:57 11:57

104 Q. Then if we just scroll down, if we continue looking at the table, please, to page 92. Scroll down, please.

That's it. Just pause there. "Location of New Community Accommodation Based Services", and it says there:

"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."

So was the issue then that patients were being resettled out of Muckamore into a particular area, but then that was putting pressure on the already pressurised community services? 11:58

A. Yes.

105 Q. Is that right?

A. Yes.

106 Q. And you're suggesting there a regional forum for the agreement on the siting of new services, and an 11:59 agreement on the regional protocol for out of area placements and host Trust responsibilities.

Then finally we can see there the final barrier is "Medical cover Community and Hospital". It's noted 11:59 there there's insufficient consultant cover in the community, and proposals are:

"More innovative approaches to recruitment and

retention."

So we have seen there the barriers that are outlined and the proposals that the Belfast Trust were making to resolve them. What response did MDAG ultimately make to those proposals? 11:59

A. I think that's probably something you'll have to ask Marie Heaney as the Director. I didn't get a clear understanding as to what the -- I know the presentation was given, and Marie certainly provided agreement to bring a social worker into the team. So there was bits that I could see. But I didn't get a definitive in terms of whether we were going to be able to go ahead. I think Marie could probably give you -- 11:59 12:00

107 Q. You didn't get --

A. -- I wasn't at the meeting. So. And that would have been at Marie's level.

108 Q. But you didn't get overall feedback of 'These are the proposals that have been accepted, these are the proposals that haven't'? 12:00

A. Not in that level of detail.

109 Q. But you did see changes in the system. We can see that there were additional staff brought in to the service. Is that in the form of response to your proposal on the transitional team; is that right? 12:00

A. We brought in the second -- Marie had agreed to the community infrastructure post in, I think, November/December time. That person started in

December 2020. But we hadn't social work. So it was from these conversations that I got agreement to go ahead with the social work side, was my understanding.

110 Q. If we just turn back to your statement, you do say a little bit more about the new staff introduced to the service. 12:01

Paragraph 41. So this is STM 278-10. You say:

"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."

Is that you were just referring to there?

A. That's -- yeah.

111 Q. Yeah: 12:01

"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."

So this was in effect the Belfast Trust's response to the proposal for a transition team; is that right?

A. [WITNESS NODS].

112 Q. And the community integration post that started in December 2019, then a social worker in 2020, you've referred there to the community integration post being divided and one working on the Belfast Trust and one other Trust. What way did the social worker work? What way was their time divided? 12:02

A. The social worker was connected to the Belfast Trust community integration post, so they were working on doing Essential Lifestyle Plans for Belfast Trust patients, because the other Trusts had their own resettlement staff. 12:03

113 Q. And in terms of development then, you say that it was intended the team should have been developed further. Did that development take place? 12:03

A. I can't say after June 2020. So there wasn't anything further.

114 Q. But in the time that you were in the role - so you were in the role until June 2020, so in December '19 you experienced the second community integration post, then a second social worker in 2020. Around that time were you discussing the development of the team with anyone 12:03

in the Belfast Trust?

A. Yes. But there wasn't any definitive plans at that stage to increase staff further, that I was aware of.

115 Q. And was that a resources issue or was there anything else feeding in to why it wasn't being developed further at that time? 12:04

A. In the post that I was in, you didn't have a budgetary responsibility. So it wouldn't have been within my sort of financial resources to do or to make changes like that. I was aware that the community teams continued to have pressure in relation to their own staffing. So I probably couldn't comment any further than that. 12:04

116 Q. But with the additional staff that were put in place, do you think that that was of benefit? Did you start to see benefits to the resettlement process? 12:05

A. Yes. Yeah. I suppose my intention at that point was to prevent any more unsuccessful placements so that that's -- it was work to, I suppose in my view, catch us up to where we needed to be with some of the assessments. So, again, I wanted to do more. There is only so much you can do with one, having one person in post doing the plans. Sorry, say that to me again? 12:05

117 Q. Could you see a benefit to the resettlement process with the introduction of these staff? 12:05

A. Yes. Yeah. Yes. And it allowed relationships with a number of families to start developing. And I had mentioned earlier that we were able to work on the assessment processes that we were doing, and improve

those, and we were able to look at bringing that learning through from those unsuccessful placements into practice. So we were starting to build staff that had sort of an oversight and understanding of some of the challenges that had been encountered.

118 Q. And I'm going to come and look at your paper in respect of trial placements, but just while we're looking at your statement, in the next paragraph, if we could scroll down to paragraph 42 please, you do refer to a comparison with the South Eastern Trust there that I want to ask you about. You describe:

"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."

Can you say a little bit more about why the South Eastern Trust's model appeared to be more successful? Was it about them having less patients, or was it about their model and how they were going about things?

A. Somewhere I have the patient numbers in the different Trust areas. But, yes, they could well have had lower numbers than Belfast Trust. But there was -- when I met with the member of staff who had been responsible for that work, I was aware that she had a really good understanding, and the communication seemed effective between her and the families, and families

knew how to communicate, and they had a person specifically to communicate with on that. So -- and the Essential Lifestyle Planning does give you a good foundation to discharge work. So. And Essential Lifestyle Planning isn't just purely for discharge, you know, it is...

DR. MAXWELL: Was there any difference in the needs of the people? So -- and Professor Murphy can correct me when I'm wrong here, but I think the instance of learning disabilities is higher where there's economic deprivation. Would that affect the case mix of different Trusts? 12:08

A. Yes. To be fair, I haven't explored that at the time.

DR. MAXWELL: I mean it may not be. I just wondered if that was apparent -- 12:08

A. Something. Yes. And it's certainly something that we're exploring in different ways at the minute and seeing how that impacts people's experience and life. But it wasn't something that I would have looked at at the time. 12:09

DR. MAXWELL: Okay. That's okay. That's fine.

119 Q. MS. KILEY: And just in terms of your experience of the changes that were made after the barriers had been identified and your proposals were made, you've referred to the introduction of new staff. Were there any other changes that you experienced? 12:09

A. I suppose I'm just coming back to what you were saying there. I wouldn't have had a sense that some Trusts had more complex people than other Trusts, certainly

that wasn't apparent at the time. So, sorry, go ahead.

120 Q. I was asking about -- you had referred to the additional staff that came into place after -- in December '19 and then in 2020, and thinking to the barriers that we just looked at and the proposals that were made, did you experience any other changes that arose from your proposals, aside from the staffing? 12:09

A. A slight consequence is potentially that some of the discharges, or a couple of the discharges would have slowed at that point, because when you were having to go back and do more detailed assessments, or flagging that there were issues with something, it was a matter of spending more time going in to make sure that we had things as detailed and as comprehensive as we possibly could, to avoid having unsuccessful placements. So that took a bit of time and energy to get there. But for me it was really important to get that right, because it is much -- for lots of reasons; for the individual, for the family, for the provider, for the service, it's -- if somebody has an experience of an unsuccessful placement, that is causing setbacks for everybody, and a really negative experience that then is much more difficult to move forward from in the future, and it's not something that we want to do. So. And some of that did take having to say, 'Look, I think we need to spend another couple of weeks', or 'We need to work on this aspect', or 'Let's explore this', and then you explore it, and if it's okay you move on, and if things come up from that, then it was a matter of 12:10 12:10 12:11 12:11

dealing with them. So I think what I would say at that stage was that I had more assurance in relation to the discharges because I felt the information was improving, but not necessarily as much as I would have preferred it to be. 12:12

121 Q. But in terms of the other proposals that we looked at, some of them related, for example, to a regional workforce strategy and the regional forum to discuss placements. Did you have any feedback on whether those were accepted? 12:12

A. I know there was conversations about workforce, but some of those may have been in the system beforehand. I can't actually say.

122 Q. But are we to take it then you didn't experience changes in those things whenever you were in post? 12:12

A. Well I think for me, I was working on trying to get conversations started and generated. So for me I was flagging things that I thought would improve things, which is effectively what my role was when I was there. And you've got to take into account that this was, 12:12 what, February time? So we were into lockdown in March and then I finished at the end of June. So there was only sort of a couple of months after that. But certainly conversations were being had.

123 Q. You refer to the learning from unsuccessful trial 12:13 placements, and I want to come on and look at your paper on that now. It appears at page 43, please.

A. And apologies if I've forgotten something.

124 Q. I'll bring you back if there is anything else that

I need. There is "Summary of Learning from Unsuccessful Trial Placements", and it is dated there just at the very bottom of the page, you can see June 2020; isn't that right? So you completed this paper just before you left post; is that right? 12:13

A. Yes. Now the unsuccessful trial placements had happened over a period of time. So.

125 Q. So whilst the paper is dated June 2020...

A. 2020, yes.

126 Q. ...your experience and understanding of the unsuccessful placements also fed into the barriers that you identified and the proposals that you made; is that right? 12:14

A. Yes. Some of them, yes.

127 Q. And if we can just scroll down, can you explain what the purpose of the paper was? Why did you bring all this together in this one paper? 12:14

A. It was for learning purposes. So it was for us to learn and improve what we were - how we were planning and doing discharges. While the first part of the paper was sort of broader themes, sometimes it was -- I divided the paper into Part 1 and 2. So Part 1 was identifying the themes, but sometimes that doesn't really help staff really understand what that might look like in practice. So the second part was to give the actual practice examples so that people could start thinking in more detail about, Oh, well while a TV, or Wi-Fi, or something, may not seem particularly important during the larger discharge planning, if 12:14 12:15

that's important, and really important to that individual, then that will weight the response and whether that might trigger other behaviours or, you know, and having things in place in terms of staffing, or staff leaving a scheme, or changes in a manager in a scheme are all things that people may just go 'Right, okay, somebody is leaving', but actually there are consequences and implications that need to be considered within that. So it was to really help staff understand that some of these things that they're seeing are actually more important and that a series of those things can potentially lead to a placement breaking down, and that a lot of those are potentially avoidable before you get into a crisis situation. So it's about planning and thinking about what the possible eventualities might be. 12:15 12:16 12:16

128 Q. And is an external document essentially then for the Belfast Trust to learn about the unsuccessful placements?

A. No, I had it written into the first couple of pages of the document, because I was conscious when I was leaving that I wanted to pass on as much information and knowledge as I possibly could, and I did say in it that this would also be useful with independent sector providers. So that they had the same understanding as we had. 12:16 12:16

129 Q. If we can move down to page --

CHAIRPERSON: Sorry, where did you expect it to end up?

A. Where did I expect it to end up?

CHAIRPERSON: Yes.

A. Certainly conversations within the Trust. I would have hoped some direct training linked to it, because we didn't have any training on resettlement at this, or specific training on resettlement, so I was thinking this would be a good basis -- 12:17

CHAIRPERSON: So although it might have had wider implications, certainly when you wrote it, it was aimed as the HSCT.

A. It was aimed at the health and social, but, no, I have a sentence or two that it would also be really useful to share this information with the independent sector, because they're on this journey with us together. 12:17

130 Q. MS. KILEY: I think we can see more detail on this on the next page, 45 please. 12:17

A. I could probably find you the -- that's in the first couple of pages of it.

131 Q. If we go down to page 45, you'll see it come up on your screen. Just pause there. Can we see the whole of page 45? That's it. Thank you. I think this is the part that you're referring to, the final paragraph there you say: 12:18

"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..."

A. If you scroll on down, there's reference to improve the assessment, highlight values, coordination -- the learning is as relevant. So, right, it's the second paragraph down I've said: 12:18

"The learning is as relevant to Independent Sector Providers..."

Maybe "ISPs" was not helping. So it's: 12:18

"...as relevant to Independent Sector Providers as it is to Health and Social Care Trusts and it is intended that the summary could be used by the Trust's Resettlement Teams to develop a learning opportunity to share with the new providers, their managers, staff and as part of learning for new developments."

So my intention was for the system.

132 Q. And did you present it to anyone when the report was finalised? 12:19

A. No. Because I was literally leaving in June. So.

133 Q. So the --

A. When I say "presented", it was shared internally, it was given to the co-director, and when I was aware of other staff moving to Muckamore, even after I had left, I continued to share the document, because I wanted to make sure the learning was in the system. Plus all the staff within the resettlement service had it. But 12:19

I can't -- I don't know exactly what was done with it afterwards.

134 Q. After you left.

A. But I did my best with it.

135 Q. If we can just look at exactly what you looked at. Go back up to page 45 please and the top of the page, and just pause there. It says that: 12:20

"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."

I want to ask you about the reference there to the unsuccessful placement being treated as either a shared learning event or a significant event audit. Was that something that only happened for the purposes of the presentation of this paper, or were all failed resettlements always treated in that way? 12:20 12:21

A. In Belfast Trust, yes.

136 Q. Do you know what time period that started in?

A. It was in place when I was arrived, in fact it must have been there before, because I was able to pick

these up from February 2019. So I think -- my understanding was Marie had put this in place, Marie Heaney at some point, but I don't know exactly when that was started.

137 Q. But had there ever been a paper like this that brought together all the learning from those individual events that you were aware of? 12:21

A. Not that I'm aware of. I also did offer to come back and do training. So...

138 Q. This was in connection with the paper; is that right? 12:21

A. Yes.

139 Q. And you offered to come back and do training for who?

A. Any of those groups. So when I was leaving I said, you know, I felt this was very important learning and that I would be happy to come back and be involved in any training. 12:21

140 Q. Were you taken up on that offer?

A. No.

141 Q. Can we move down to page 45, please. I beg your pardon, 46. The next page. Towards the bottom of the page, just pause at the bullet points, please. The paper sets out a number of detailed themes, but you summarise them here in the final paragraph: 12:22

"The key themes that have led to placement breakdown during leave on trials regularly involve deficits in the following areas:

Communication

Assessment..."

Scroll down, please?

"Care plan and discharge planning 12:22
Provider is unable, or the providers community environment is unsuitable to meet needs, which was not fully recognised or addressed in the stages above."

And then just scroll down: 12:23

"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."

And you've already described how the main report then is broken into Part 1 and Part 2, and we can see Part 1 there "Key Learning", and you have "Learning & 12:23
Recommendations", there are a total of 24 points in this section, so I'm not going to ask you to go through them all, but if we can just scroll down, please, so we can see start to see a number of these, and I'll pause. I'll pause at point 1. You describe how: 12:23

"Significant areas have been missed in the assessment process, in particular the exploration of behaviours that have become well-managed in the ward setting..."

And the final sentence you say:

"Involving Psychology in the assessment process is being established to improve the assessment around identifying and managing behaviours."

This was in 2020, and it refers to psychology being established to improve the process. So does that mean that in 2020 psychology was not routinely involved in the assessment process? 12:24

A. Psychology were -- my understanding was that they were routinely involved in Muckamore on the site, but not routinely involved in the assessment process. So what I wanted to do was -- what I could see was that they were joining very close to discharge, and actually what I was hoping was to, or my intention was to get them involved much, much earlier, because they were skilled in terms of picking up, you know, some of their knowledge, and sharing some of their knowledge from working with that individual on the ward, and then that was really helpful information to be shared to see if there was any gaps or things that may not translate well. Say, for example, somebody is sensory. So something that may not translate well to a community setting, or something that we might need to explore a bit further. 12:24 12:24 12:25

142 Q. Was it surprising that psychology was not involved at that earlier process, given the complexity of some of

the resettlements?

A. Well, they could well have been involved in a number of cases historically. I didn't have that knowledge. But when I was there, there was cases that I was going I really want, you know, the psychology input was really valuable. And they had done some exceptionally detailed work with PBS plans and supporting providers in the community. So I was able to see how much they could bring to supporting people. So there was less of that on the mental health resettlement, and we wouldn't have had psychology on the team, so I saw it as a real benefit to learning disability services that they had PBS and psychology deeply engrained in their services. 12:25 12:26

143 Q. If we can move down, I want to pick up on point 5, please? You say: 12:26

"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."

So does this link in to what you were saying earlier about resettlement lists? So the resettlement list seemed primarily to be formulated on the availability

of a placement opportunity, but you were saying that something different should happen here and that it should be based on the assessed need; is that right?

A. Yes. Well, assessed need is sort of the foundation to any piece of work that you would be doing. And I also should caveat that with, you know, this wouldn't have applied to everybody, but a number of the cases that I was looking at, that this was nagging as an issue. 12:27

144 Q. Can we move down to point 8, please? One of the other issues that you identified was staffing. You can see there: 12:27

"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."

So are you talking about the salary scale for those persons working in the private and community and voluntary providers? 12:28

A. Yes.

145 Q. Later on, if we move down to paragraph 11 there, you've referred to communication, which you've already referred to in evidence. But it says: 12:28

"The communication between multiple agencies benefits significantly from a dedicated individual with the responsibility to have an oversight between hospital

and community settings."

Was it the case then that in a number of the field resettlements that you saw that patients weren't having a dedicated individual worker? 12:28

A. Yes, in a couple of them, and some of them -- you know that's -- I can't remember the very detail of it. But, yes, I -- the community teams didn't have the capacity to do the very detailed comprehensive work, and while they may have had an individual, that individual had a 12:29 caseload of maybe 40/50/60 other people. So that has an impact on how much time and attention somebody can afford that. So with the transition team, then you can have that dedicated individual who has that oversight across all the different settings, and focus on that 12:29 person's, that patient's journey.

146 Q. There are a number -- in the 24 points that you've outlined, there are a number of challenges. Some relate to issues in the hospital end of things, so dealing with assessment that we have looked at, others 12:29 relate to the providers and potential in terms of the complexities and challenges that they may face. Is the common theme in all of these a lack of resources? So a lack of resources for hospital staff to be able to appropriately plan resettlement, and then the lack of 12:30 resources in the community for providers?

A. Obviously resources are part of it, but I don't think it's just as simple as maybe a financial resource. Because you also need training, you need staff

resources. So it's a broad understanding of resources is really...

147 Q. But in your experience it was affecting not only -- it was that lack was evident not only at hospital, but in the community teams, and then also in the providers. So there were issues at a number of steps of the way; is that right? 12:30

A. Yes, resources have an impact, yes.

148 Q. Can we move down to page 52, please? You set out there the red flags to placement breakdown. You provide a list of red flags that should be treated. 12:31

"...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."

Did you see then the list of these sorts of issues in the failed replacement that you looked at?

A. These are into the specifics of the six that I reviewed, yes. 12:31

149 Q. And whenever you could see them then, looking at the review of the audit, so were there reasons why these issues weren't then picked up as red flags at the time to stop those six placements becoming failed? 12:31

A. I suppose I described it later just in terms of attention to detail. It's hard to know, because I wasn't there for -- I didn't watch some of these earlier SEAs unfold, and it wasn't until maybe one or

two at the end that I actually got to see, you know, the detail of what was happening, and got to ask the questions and probe those further. Whereas the previous ones, it was -- I was getting the information from the SEA form itself and from conversations with staff that had been involved in the unsuccessful placements. And families. I had conversations with some of them as well. So it was really to -- it was drawing that information together. Sorry, what did you ask me again? Sorry. 12:32

150 Q. Whether you were able to identify these as red flags to placement breakdown when you were reviewing the SEAs, but because they did fail it seems that they weren't identified as red flags at the time.

A. At the time. 12:33

151 Q. And was there a reason for that? You particularly referred to communication difficulties, so I'm wondering was there a communication issue between the --

DR. MAXWELL: Can I ask a specific question about this, because with an independent service provider I would have expected that to be in the contract, because these are incidents that should have been reported in incident reporting systems. 12:33

A. Yes. 12:33

DR. MAXWELL: So you may not have had the opportunity to do this, but there's a bigger problem if the independent service provider is not reporting incidents. So that's a breach of their contract.

A. Yes.

DR. MAXWELL: But it may be that they were reporting it and nobody was doing the contract managing and picking up these things, and it may be that that detail wasn't in the SEA so you couldn't look at it. 12:34

A. Yes.

DR. MAXWELL: But did you have the opportunity to look at the contract monitoring and whether these had been identified there?

A. I didn't look at the contract monitoring. I'd be very familiar with the contract monitoring process, and if somebody wasn't putting through incidents reports, that that then needs to go through Datix and be recorded internally and back to the contracts manager. 12:34

DR. MAXWELL: Yes. But you couldn't tell from the SEA reports whether these were incidents that had been reported or not through contract monitoring? 12:34

A. No. I think one of the things, it's probably later on -- you see that would have been managed by the care management. 12:34

DR. MAXWELL: Yes. No, I appreciate that.

A. Community side. So I didn't have an oversight of some pieces of it.

DR. MAXWELL: Yes.

A. But what I did find was that it was being managed through emails which -- and I think I was at meetings where I was hearing of some of these incidents happening, and it was also a matter of maybe somebody would report something on the ground, but did that 12:34

actually translate into an incident report?
DR. MAXWELL: So the governance wasn't joined up between commissioning and the contract management and you as care managers?
A. Yes, in a couple of -- I can't say that that was across the board. 12:35
DR. MAXWELL: No, no,.
A. But, yes, I did find examples.
DR. MAXWELL: In the ones you looked at.
152 Q. MS. KILEY: And we can see there, if you move down, there are a list of flags to placement breakdown, again I'm not going to go through them all; but was your intention that these would essentially be used as check lists so that people who are overseeing the resettlement, future resettlements, would be able to note and act on these if needed and was that something that you intended to pick up on your training then? 12:35 12:35
A. Well it had been. One of the staff in the community infrastructure post and social workers did develop check lists and pieces from the learning that we were doing as we went along. So some of that was put into practice from the resettlement side. But I suppose what I was intending with this would be that that was wider than just the resettlement, because you want the ward staff to understand. Because people might see something when they are out on inreach or outreach and if everybody in the system understands, like these are just an example of flags, there are other things that in each case could potentially crop up. But it is to 12:36 12:36

get people's thinking into what some of these potential issues are so that people spot them when they're coming up or hopefully before they turn into something.

153 Q. You have told us about what you intended this to be used for, but we have seen it was dated in June '20 and you left the role in June '20; was anyone responsible for taking forward that learning to make sure that staff knew about these red flags and that the learning that you hoped to pull out would actually be put into place? 12:36 12:37

A. Well, the staff that were in the community posts, the community integration posts, were very, very familiar with the learning. We had gone on this journey together in relation to the learnings. So they had been involved with the SEAs. I had had lengthy conversations because, in order to get this learning, it involved drawing information out and then asking and challenging in a constructive way as to how do we do this better basically. Also, as I said earlier, I gave the information, I think it was probably my last email in, was making sure that this information was with the co-director and shared and then a couple of other staff that I knew going to Muckamore later I also sent some of the documents to so that they would understand and have this information. 12:37 12:38 12:38

154 Q. In terms of your provision, though, to the co-director, did you receive any feedback from the co-director on the report?

A. No, and actually the documents that I have attached

here were the documents that -- that was my last email to the co-director.

155 Q. So you delivered the report and then your involvement ended; is that right?

A. Yes. 12:38

156 Q. I want, finally, just to look at a topic that isn't picked up, I think, in the exhibits but you do refer to it in your statement and that's targets. If we could turn to paragraph 63 of the statement, please, STM-278-16. Will you just move down, please, to the 12:39 bold text, just underneath that, and you can see there you were asked some specific questions about targets as to resettlement and who set them and the input that the Belfast Trust have. If we move over the page, please, to page 64, you say in 2019, so this is when you come 12:39 into post:

"...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."

Can you explain a little bit more about why you felt 12:40 that it wasn't achievable, person centred or safe?

A. Well, I suppose when I heard -- I was very surprised when I heard the announcement because I was aware that there was a considerable number of people still

in-patients in Muckamore and therefore the idea that they would be discharged by December 2019, I think it was the summer of 2019 that I heard that message. I don't have the exact date of that. My immediate reaction to that is, well, that's not likely to be achievable. And I do also acknowledge that, you know it's useful to have dates and dates can be a driver to moving things on. But I was concerned when I heard the announcement. That's also with a caveat that I fully believe that people should not be living in hospital and that resettlement, I've been a supporter of resettlement obviously because I have spent a huge amount of my career working within resettlement.

157 Q. But your concern was about achievability, was that because of what you were seeing happening on the ground, did you think that the resettlement model that was in place would be unachievable to resettle those patients?

A. When I heard the announcement I wasn't working in learning disability, I was working in mental health services. So I didn't know at that point exactly what was happening in learning disability. So it was really more based on an idea, in terms of the numbers and the amount of planning and the work that we did in mental health in order to -- the idea of moving 50 people in six months, well I think one of the figures was 56, there must have been probably nearly 60 people at that stage, you could not do that number of discharges safely in six months unless you had an absolutely

massive support system around it.
DR. MAXWELL: Did you think the creation of your post in LD was related to this announcement because you started in late 2019, didn't you?
A. Yes. 12:42
DR. MAXWELL: So do you think the pressure from the Department of Health to achieve this had been one of the reasons they created the post for you?
A. Potentially. I don't know.
DR. MAXWELL: Did you feel under pressure to meet some 12:42
sort of target even if it wasn't the ideal resettlement, was there ever any pressure to get people out even if it wasn't quite the gold standard you were looking for?
A. I probably got both messages to be fair. So I think 12:43
there was support, it was mixed. I got different messages.
DR. MAXWELL: But there was some saying, no, we have got to get it right and some going we have got to hit the target? 12:43
A. There was definitely a pressure felt within the system and I got that messaging from staff on the ground as well and other trusts, it wasn't specific.
DR. MAXWELL: Where did you perceive that that pressure was coming from? 12:43
A. I think there was a drive to resettle and close the hospital.
DR. MAXWELL: Yes.
A. That's a perception that I had. But apart from the

messaging that came out in the summer, nobody actually turned around to me and said 'you have to have everybody out of here by December.' That was one of the reasons why I said to Marie I can only give you an assurance that I will tell you what I believe is happening, I cannot give you an assurance that I am going to get more people out of hospital. That was quite a challenging position. I couldn't -- I didn't feel I could speed up resettlement.

12:44

DR. MAXWELL: So when the person --

12:44

A. I was probably going slightly the other way, to prevent the unsuccessful placements.

DR. MAXWELL: So when the presentation to MDAG, the "Homes Not Hospitals" presentation happened, well it wasn't the first target, as we know, but the latest target for resettlement of December 2019 had been missed, because the presentation to MDAG was in 2020, wasn't it; did you get any -- were you at that meeting?

12:44

A. No.

DR. MAXWELL: Did you get any sense of feedback that there was a frustration that the target had been met and that they had to try a different way of doing it, or did that just not get discussed?

12:45

A. I didn't have those discussions, so I don't know.

DR. MAXWELL: Thank you.

12:45

MS. KILEY: Ms. Rowan, I have no further questions for you. It may be that the Panel have some more.

MS. ROWAN WAS THEN QUESTIONED BY THE INQUIRY PANEL AS

FOLLOWS:

158 Q. PROFESSOR MURPHY: I have just got one more following on from what you have just been saying. What would you have said was a realistic target date? 12:45

A. That comes back to I wouldn't want to put a target date on it because you need to have your plans in place. And without having robust plans in place, so you need to have a robust assessment that tells you exactly what somebody needs, you then need a community plan to 12:45 deliver on that, and, until you have that, then it would be very difficult to...

159 Q. PROFESSOR MURPHY: Yes, sure. But when you were in mental health services in 2019 and you heard this announcement, you say you were shocked at the rate they 12:46 thought they were going to go at?

A. Surprised.

160 Q. PROFESSOR MURPHY: So you must have had an idea in your head about what rate would be sensible or reasonable or realistic? 12:46

A. Hmm, I didn't look at it from that perspective. I looked at it from the service -- the patient or the service user journey as to what is reasonable for somebody to be discharged and out of the hospital by. I think that's an easier position. But I also 12:46 understand that sometimes it is useful to apply some sort of parameters and timeframe, in fact it is useful. On that example, that was part of my reason, my drive to apply because I thought that there is some

information in the system that doesn't tie up with my experience of resettlement.

PROFESSOR MURPHY: Thank you.

161 Q. CHAIRPERSON: So you're not against targets?

A. I'm not, I'm not against targets. 12:47

162 Q. CHAIRPERSON: Provided that there is sort of a holistic approach and that you're given sufficient resources to make that target feasible?

A. Yes, that is a very reasonable position, yes.

CHAIRPERSON: Do you have anything else? Can I thank you very much for coming to assist the Panel. We have asked all our questions, I think, as we have gone along. So as I said at the beginning, thank you for your statement, but thank you for your time this morning. 12:47

THE WITNESS: Thank you.

CHAIRPERSON: We can now let you go. Okay, we'll sit again at two o'clock.

THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT AS FOLLOWS. 13:39

MS. TANG: Good afternoon, Chair, and good afternoon, Panel. This afternoon the Inquiry is going to hear evidence from Ms. Fiona Boyle. Ms. Boyle is an independent consultant who has carried out two reports which were requested by the Northern Ireland Housing Executive, and they focussed on resettlement of patients from long-stay learning disability facilities 13:54

in Northern Ireland.

She provided a copy of -- she provided a statement to the Inquiry which was dated 27th April 2023, and it exhibits both of the reports I've referred to, along with a copy of her CV. 13:54

Her first report was published in October 2014, and it focused on "Statistics, perceptions and the role of the Supporting People Programme", and the internal page reference for that report is STM 110-19. 13:55

I'll be going to a number of points in that report in the course of taking the witness through her evidence.

The second report is dated June 2017, and that focussed on the experience of learning disabled people who were resettled from long-stay hospitals. The internal page reference for that one is 110-107. And I'll also take the witness to some points in that report. 13:55

Chair, if there are no other issues, we could call the witness, please?

CHAIRPERSON: Yes, please.

MS. TANG: Thank you. 13:55

MS. FIONA BOYLE, HAVING BEEN SWORN, WAS EXAMINED BY MS. TANG AS FOLLOWS:

CHAIRPERSON: Well, welcome to the Inquiry. Thank you very much indeed for your statement, and your reports, and thank you for coming to give us your time this afternoon. I'll hand you over to Ms. Tang.

163 Q. MS. TANG: Thank you, Chair. Hello again, Ms. Boyle. We met a short time ago, but just to remind you I'm Shirley Tang, I'm one of the counsel to the Inquiry. Can I just mention first of all to you that I understand you have hard copies of your statement and exhibits with you, and you told us beforehand that you have some notes made on those statements? 13:56 13:57

A. That is correct. Just for my own purposes I have annotated some of the reports so that if I'm asked about those items, I'll be able to reference those.

CHAIRPERSON: That's fine. As long as they reflect your own thoughts, and not a lawyer or somebody else. 13:57

A. Absolutely just my own thoughts. If I might add, the first report was 2014. The second is 2017. So from my perspective, that requires a bit of memory recall, which is why I've gone back through them and made a couple of notes. 13:57

CHAIRPERSON: That's fine. Thank you.

164 Q. MS. TANG: Thank you. So, Ms. Boyle, one of the things I need to check with you first of all is that, are you content to adopt your statement as your evidence to the Inquiry? 13:57

A. I am, yes.

165 Q. Thank you. And as I had advised you before, there's a screen in front of you, where I take you to a

particular point in your statement, or any of the reports, it should come up on the screen. Do let me if there's any issue with that?

A. Okay. Thank you.

166 Q. Thank you. And, finally, can I just ask you to try and remember to keep your voice up. The Panel may alert us at some point if either of us are too quiet? 13:58

A. Okay. Thank you, yes.

167 Q. And try not to speak too quickly as well because our stenographer is trying to catch the detail. If you need me to repeat anything, please say, or if anything is unclear, again, please let me know. So can I turn to your statement? Your statement tells us you've been a principal consultant in your own business, I take it? 13:58

A. That is correct. I'm a sole practitioner trading under the name Fiona Boyle Associates since May 2002. 13:58

168 Q. Yes. And from your CV that you have exhibited with your statement, do I understand that before May 2002 you were a director in a homeless charity up until that point? 13:59

A. From 1995 to 2002 I was Director of Research and Development at the Simon Community. That is correct.

169 Q. And when you were working as a sole practitioner, the Northern Ireland Housing Executive then commissioned you to conduct some research and to produce two reports for them? 13:59

A. That is correct. And just as background, the way that operates is that these go out for public procurement, and there is then a procurement process, and I would

have been part of the team for the first report, alongside John Palmer and two others who are noted on the report, and for the second one that was with John Palmer.

170 Q. So your first report was published in October 2014, and that was very much looking at the statistics, the perceptions, and really how the Supporting People Programme had worked. And at paragraph 8 of your statement, that's on page 110-3, which should be just one down from this page. Thank you. You explain that that research was really intended to explore the way in which the resettlement programme had been managed, and the role of the Supporting People Programme, and also to give some insight into the lives and experiences of people who had been resettled as a result of it. We're going to look at that report and the second of them, which is the June 2017 Report, which focused on the experience of learning disabled people. 13:59 14:00 14:00

We'll look at each of those in some detail, but I want to just go through your statement first of all and we'll pick up on some points from that. 14:00

So if I can look at paragraph 7 on the page? Thank you, there it is. You have made reference there to the Supporting People Programme. Can you tell us what that is or what that was? 14:01

A. So the Supporting People Programme is very much revenue that is provided to providers who are supporting people

in supported housing. That sounds a bit repetitive with a lot of "support" and a lot of "housing". Perhaps I could also, just to give that more context? The schemes, the supported housing, the capital element of that is supported by Housing Association Grant, HAG as it is known, and that is provided by the Department for Communities. That has been in place, I would say, for at least 30 years, maybe more. The first housing associations were operational from the 1970s. So the scheme, or a scheme, would be built through HAG, that's the capital element; then housing benefit, if the person is a tenant who is eligible for that, there's the housing benefit element; then the Supporting People element is really for housing-related support; and then alongside that a fourth element would be from the Health and Social Care Trusts. We have five in Northern Ireland, and they would be providing the support for the support staff, for any domiciliary or personal care. So there are different funding streams for the capital side and for the revenue side. 14:01 14:02 14:02 14:02

171 Q. So is it the case that the Supporting People Programme would support lots of different types of people, or is it learning disability specific, or how does that work?

A. The first part of your question is correct, yes. So my understanding is that the Supporting People Programme has four thematic groups: younger people is one, older people is two, homelessness is three, and I think the term is "disability and mental health" is the fourth. So in terms of our topic here, we would be talking 14:03

about that fourth thematic group. They are set a budget under Supporting People. I don't recall if I have it in this statement, it would certainly be in the 2014 Report, and I think at that point it was around 72 million. That had not been uplifted since around 2008. So as a result, within those four thematic groups there would be competing priorities and requirements.

172 Q. So do I understand you correctly, 72 million is to cover all four groups. It's not for any individual? 14:04

A. Correct.

173 Q. And whenever there was an allocation, or when there were decisions made about how to divide that money up, how did they do that?

A. So I think it's probably taking me slightly out of the research. 14:04

174 Q. Yes. Fair enough.

A. But my understanding would be that there would be different planning processes, different commissioning processes to assess at a strategic level what needs are coming forward. If I may just refer to one other document that I have here? So, for example -- would you prefer me not to go off the record? 14:04

175 Q. I'm just mindful that the Panel and the members of the Core Participants haven't seen that document? 14:04

CHAIRPERSON: Just tell us what it is first of all.

A. Okay. So I suppose there are other documents that would envelope around the whole commissioning process, the assessment of need, and I've just written down a

couple of them. For example, the Supporting People Strategic Needs Assessment of 2020, it noted significant changes in the numbers coming through, particularly around disability and mental health. There was the 2015 review of the Supporting People Programme, and it recommended stronger relationships between all of the players in this type of field; and then, for example, the DFC's Housing Supply Strategy, which again called for the need to look at more options around supporting supported housing, and I suppose I'm using these to illustrate the complexity of all of this. 14:05 14:05

176 Q. Mm-hmm.

A. That it wasn't just one theme of housing need or social services need, and there wasn't one element of 'Well here's how we're going to deliver it'. It had to take everything into account. 14:06

177 Q. Okay. So would it be fair to say that, for instance for disability and mental health, there would have been those review exercises that you referred to? Presumably for the other elements of the scheme they would all have their own voices arguing for various levels of need as well? 14:06

A. That's correct.

178 Q. So would there have been a level of competition between the different strands for the funding, to your knowledge? 14:06

A. To my knowledge I can't comment in the sense of subjective competition for it. I think it would have

been based on different needs analysis across the four thematic groups and across a whole range of other factors.

DR. MAXWELL: Can I ask you, you've illustrated the complexity in different departments, was there anywhere where this was all brought together into an overarching view? 14:07

A. I think in our 2014 research report we have commented that in our opinion there wasn't an overarching resettlement programme, and by that we mean there would have been a programme that would have taken everything as you've mentioned into consideration, both the capital bills side of things, and then all of the revenue and the support elements that were required. 14:07

DR. MAXWELL: To your knowledge has there been an overarching forum created since then? 14:07

A. My understanding is that things have progressed significantly and, yes, that is much more now in play.

DR. MAXWELL: Well, it might have got better. Is it a comprehensive forum now? 14:07

A. I would not have the knowledge to be able to comment on that.

DR. MAXWELL: Okay. Thank you.

179 Q. MS. TANG: I want to go down now, if I may, to paragraph 9, which is also on page 110-3. Thank you. 14:08 And you can see there there's reference to the:

"...research determined that the resettlement of patients from MAH was significantly different to the

other two long stay hospitals for reasons..."

- that you go on to discuss, and that part of the reason for resettlement being so slow at MAH was due to the number of patients involved. However, other factors were a lack of bed spaces being brought into the Belfast Trust compared to other Trusts. I take it that this refers to the business of the commissioning placements for people who would then go on to be resettled? 14:08

A. Yes.

180 Q. Can you clarify for me who would have determined what bed spaces were allocated to the different Trusts? Is that the way it works? You look thoughtful there?

A. Yeah. I'm not actually completely sure how that process of the different Trusts factoring in what their needs were, who they knew was on the priority transfer list, the PTL, or the delayed discharge list, and how that mechanism came into a system in order to either establish was there already a bed space that could be utilised, or do we need to build or get something bespoke? 14:09

181 Q. Mm-hmm.

A. So I'm afraid I can't go into any further detail on that process. 14:09

182 Q. Okay. Thinking back to the resettlement from Muckamore particularly, compared to the other two long stay hospitals, what would you say was the main difference that you were conscious of in that?

A. I think from our research and looking both at the quantitative data that we analysed and the qualitative feedback, one of the principal issues was the numbers at Muckamore were much higher than, for example, at Gransha or at Longstone. But more than that, the individual patients, their needs were more chronic, profound, severe, whatever definition is in use, not just in terms of learning disability, but there were more patients who would have had a dual diagnosis of potentially learning disability with mental health, or connection to forensic background, and because of those complexities, it would, therefore, be more difficult to find suitable supported housing. So that was one of the main factors in a longer resettlement timescale. 14:10 14:10

183 Q. Mm-hmm. Did you detect in your research any difference in the approaches taken by each of the Trusts when it came to trying to make resettlements happen? 14:11

A. By the time we got to the research, which was really 2013/2014, the site at Gransha was closed. So we really had very limited interaction there, other than to say resettlement has been completed. And Longstone, again, would have been very limited. So our main focus really was on the fact that the target had been 2011 for Muckamore, but by the time we got to this 2012/2013 timescale, that target had not been met. 14:11 14:11

184 Q. Just thinking back more generally, is it your understanding that there is a higher prevalence of severe or profound learning disability in the Northern Ireland population? Does it differ, for instance, in

incidence to somewhere like England, or Scotland, or Wales?

CHAIRPERSON: Can you keep your voice up, sorry? I did hear that, but...

MS. TANG: I can. I will of course, sorry. 14:12

A. Can I refer to paragraph 13 in that -- in response to that question? Perhaps this doesn't entirely answer the question you've asked about the propensity or the nature of learning disability, but we did comment on the fact that there was a much higher population of 14:12 people with a learning disability placed in hospital than per head of population in England and Wales. I imagine, we haven't gone into it in detail, but that will have been a historical factor potentially back to the 1950s/1960s where, again I don't have categoric 14:13 evidence, but one would assume that perhaps there were much fewer options here in the North of Ireland and Muckamore was the main option.

185 Q. Mm-hmm.

DR. MAXWELL: And that might well be true, but you 14:13 didn't actually look at the incidence or the rate of diagnosis?

A. Could I take a moment just to look back at the report just in terms of my recall at this point?

DR. MAXWELL: Of course. 14:13

A. (Short pause while witness looks at the document). In answer to that question, if I could refer to pages 16 onwards of the 2014 Report, and we looked at prevalence in Northern Ireland, but as far as I can recall not

with a comparison to other jurisdictions. There were some issues with the data.

MS. TANG: I'll just let our technical folks know that the page reference for that is 110-34. It should come up on the screen in front of you there. Yes. So you were just saying that you hadn't necessarily looked at the other jurisdictions, it was really just looking at Northern Ireland, and that was Prof. McConkey's data that we can see there. 14:15

A. Correct. Yes. 14:15

MS. TANG: Dr. Maxwell, I'll just let you complete your question.

DR. MAXWELL: I just wanted to -- you did say earlier, and I'm trying to find it, that there was a change in the rate of people coming through with mental health and disability. Maybe I've misunderstood that? 14:15

A. I think that was with reference to one of the Supporting People reports.

DR. MAXWELL: Yes.

A. Which is more laterally. Which looked at the four thematic groups. 14:15

DR. MAXWELL: Yes.

A. And has found that over time there are more individuals with mental health needs that need supported housing. So that was a separate comment, in a sense, to the nature of learning disability. 14:16

DR. MAXWELL: Okay. So did that, as far as you can recall, relate to people with mental health diagnoses, or people with LD and mental health? Because we've

heard from other witnesses, and I think you've just said it as well, that at Muckamore they had more people with dual diagnosis. Was it the proposition that there's a higher number of people with LD and a mental health disorder in later years? 14:16

A. I think at Muckamore that was the situation. Initially the priority transfer list was worked through for resettlement, and then when it got to the delayed discharge list, there would have been a higher level of individuals with possibly multiple diagnosis as well, 14:16 maybe a physical disability as well as mental health and/or learning disability.

DR. MAXWELL: So it was a change in the Muckamore population and not a change in the prevalence across Northern Ireland in general? 14:17

A. So that comment I've made refers to Muckamore, yes, in the sense that I suppose as the numbers reduced in Muckamore, and more and more people were resettled, you then were ending up with folk -- because it was more complex, their needs were more complex, not just in 14:17 terms of their diagnosis, but also their support needs, and potentially their family needs in terms of location. So that would have narrowed down the need basis.

DR. MAXWELL: Thank you. 14:17

186 Q. MS. TANG: I want to move down now to paragraph 14 which is on page 110-5, please. Thank you. You list a number of factors there as part of your findings in your 2014 Report, and one of the observations is an

absence of a system to monitor performance, in effect, against targets. Would you say that that is specifically a Department of Health failing?

A. I think because the nature, and what our research found was it was the lack of coordination between the departments. In a sense, because there was no overall resettlement plan, I would be reluctant to place it just at one department's door, because there were the combined balances of health and housing. What we have said there is that there was an absence of monitoring performance against annual or more wider timescale targets. 14:18

187 Q. And in terms of -- I understand what you say that you don't want to pin one department on that given that it was a joint effort. 14:19

A. Yes.

188 Q. Who would have been best placed or was there anyone best placed to actually do that monitoring?

A. If I can make a comparison? In England and Wales, health and housing and social services all come under the local authority sort of umbrella. Now, I suppose at times there's criticism of that, maybe they don't always work together. But in a sense, because we are separate. Also then you have the layered effect. So you've got the Department, but then underneath that you've got the five Health and Social Care Trusts, and then you've got the individual Muckamore Abbey, the actual hospital. So in terms of monitoring all of this, it would have come across all of those 14:19 14:19

stakeholders.

CHAIRPERSON: But given the relative size of the population here, it should be much easier to do, shouldn't it?

A. One would have thought given the numbers in Muckamore that there could have been a comprehensive resettlement plan that would have brought all of those stakeholders together. 14:20

CHAIRPERSON: Yes.

A. And could have worked through. And in a sense that is what was being done. 14:20

CHAIRPERSON: Yes.

A. But we're marking that in our research opinion there was slow progress.

CHAIRPERSON: Sure. And we'll be hearing in due course from other organisations. But the obvious lead for that would be the Department of Health, wouldn't it? 14:20

A. Yes, I would agree with that, because those individuals have been placed in Muckamore because of an assessment of their learning disability. 14:21

CHAIRPERSON: Right. Okay.

A. Whether that was a year ago, or 30 or 40 years ago, yeah.

189 Q. MS. TANG: You've made an observation at 14(b), and you used the phrase: 14:21

"A misalignment between health and housing funding streams."

And obviously we've just spoken about the joint endeavours of health and the housing in terms of trying to make resettlement happen. Can you tell us what you mean by misalignment of funding streams?

A. Well, when an individual was accommodated at Muckamore, everything was provided; the housing, the social support, the medical support, everything. But when we talk about a progression to resettlement in the community, everything then needs to be re-provided under those headings. And in a sense, because there was no overall resettlement plan, then as we work down through that to operational levels, there wasn't the alignment of 'We need this and we need that and we need to it come together'. So, for example, somebody might have been deemed to be ready for resettlement, but there was no accommodation ready. So our opinion there would be that those things were not being dovetailed, they weren't operating together to produce a streamlined resettlement process. 14:21 14:22 14:22

190 Q. So if I hear you correctly, everybody had their own bit of this to do, but there was no overarching body that was driving this and saying 'Right, have you your bit done? Have you your bit done?', that process. There wasn't that driving body? 14:22

A. That would be from our research findings, yes. 14:22

191 Q. I want to talk with you now about the living arrangements that were ultimately put in place, and that would take us down to paragraph 17, which is the next page. Thank you.

DR. MAXWELL: Sorry, just before we go there, can I just pick up on paragraph 16? So you've talked about different organisations not aligning; we've heard a lot about the problems in Muckamore, where it was a medical model and the answer to everything is a social model, and if everything was a social model, everything would be fine, but you seem to be suggesting that actually it's more complex than that. Was there a way to actually say 'We need a model that incorporates both social and medical needs'? 14:23

A. So the medical needs is interesting, and I know in both the reports we pointed to -- now this would be our research evidence of this, parents/family members, who were concerned that if their loved one resettled out of Muckamore into maybe a five-bed unit with social support, how would their medical needs be looked after? So there was a bit of a dichotomy there. The evidence that we present in our second report does indicate that for most people, resettlement has worked, and that in some instances people who previously had had that medical intervention, we have some examples of that, when they were then resettled didn't actually need the medical intervention. 14:24

DR. MAXWELL: But does that also mean that there was some that did? 14:24

A. I couldn't comment on that.

DR. MAXWELL: Okay.

A. Because in a sense we weren't coming from a clinical assessment of any of the patients.

DR. MAXWELL: Okay. Thank you.

192 Q. MS. TANG: Dr. Maxwell has picked up on some of the issues around the arrangements that would have existed for people when they were resettled, and in paragraph 17, I wanted to go down to that one, it starts to pick up on some statistics, one of which was that: 14:25

"Thirty two percent of all services contained eleven or more bed spaces."

14:25

And there was reference at a separate point to the Bamford principle, where five or more was really the desired level. How did that come about that there were so many people clustered together in these facilities?

A. So Bamford's vision was that if we were moving people from a large scale institution, the vision would be to move them into schemes of five or less, as you have noted. Much more homely, much more normal daily life that all of us would enjoy. But when we reviewed where people were moving and looked at the availability and the available schemes, that is exactly what our finding was. Half had more than five-bed spaces, and indeed one third, 32%, contained 11 or more. One of the key reasons for that is that a lot of the schemes that people were moving into were what we might refer to as legacy schemes, they were previously set up much prior to any of this resettlement occurring, and they would have been of that size. 14:25 14:26 14:26

193 Q. So when you say a "legacy scheme", do you mean, for

instance, a build, a physical building that had eleven places in it as opposed to just five?

A. Yes.

194 Q. So does that mean whenever you looked at these facilities that it might have had eleven places, but were there eleven people living in it, or might there only have been five in some cases? 14:27

A. I know in the report we did look at occupancy. I would need to try to cross-reference that. I think at one point we found around 85% occupancy. 14:27

195 Q. Yes.

A. Whereas Supporting People Programme would be wanting 90 and 95% as a sort of indicator. So, yes, you could have had schemes where the number of bed spaces was eleven, but the actual occupancy was lower. 14:27

196 Q. So this number was much higher, obviously 11 as opposed to five or less, was there any discussion that you came across where people were concerned about the appropriateness of that and whether that was achieving betterment? 14:28

A. Yes. Yes. So, again, at some point in the documentation and in the research we would have looked at that. The type of comment that we would have received from stakeholder interviews on that would have been a concern that you're moving people from an institution into a mini institution based on numbers. Now, of course, that doesn't always come across, because the environment that was provided once they had resettled would have been different from the 14:28

environment within Muckamore.

197 Q. Staying in paragraph 17, if I can, and thinking about also paragraph -- sorry, page 45 of your 2014 Report. I'm probably going to confuse our technical people here, but it's on page 65 of the statement. If we could turn that up, please? And you'll see there whenever -- if we could scroll down, please, to the descriptions. That's it. Belfast Trust area. Thank you. So you can see there that Belfast Trust is listed amongst the other Trust areas, and there are: 14:29

"...seven providers working in the area who provided housing and support for learning-disabled people, but only one service identified as specifically for resettled people."

Can you tell me a little more about what that means? And that's under Belfast Trust specifically?

A. Again, I would just comment on my actual recall of something from ten years ago. My understanding of that would be that there was already some provision in the Trust area, and that people were then maybe resettled into schemes that were already existing. And then one service at that point was developed specifically. And the statement that we've made there is the Trust did not appear to have prioritised the provision of supported accommodation. 14:29 14:30

198 Q. Was that different to the other Trusts in your assessment?

A. Yes, I would concur, but that leads back to the numbers that they were dealing with - much smaller. But we've stated here, for example the Northern Trust:

"The Trust focussed its provision of supported accommodation on the resettlement programme." 14:30

199 Q. Would it help if we went back up to the table at the top of that page? I think if I recall there that shows us some of the numbers. We see that Northern Ireland, as a whole, 29. A number of supporting people. Northern Trust 14 compared to Belfast 1. Does that illustrate what you're saying effectively that -- 14:31

A. I think the other -- there are so many additional factors in this, and when we think of where Muckamore was situated, and where people then desired to be located, so there would have been a propensity for it to be higher in some Trust areas, and I think the figures relate to that. 14:31

200 Q. Yes. Yes. Thank you. I want to take you down to paragraph 19 now, which is on page 7, please. This concerns the role of RQIA. I just want to try and make sure I understand what the role of RQIA actually was in the monitoring and the regulation. Can you describe for me what aspects of the services RQIA in your view covered? 14:31 14:32

A. I think in the statement what I have said is that RQIA did not have coverage of the Supporting People element of the schemes, and going back I suppose to one of my

very first comments, which was around all of these different funding streams, you really have almost a mishmash of coverage of the Housing Association Grant, coverage of the Supporting People element, and then more of the care and support. So RQIA would, in my knowledge, really cover more residential and nursing care. So if any of the schemes had that element, they would have been covered. But if they didn't, then they would not have had the statutory powers of RQIA.

DR. MAXWELL: So are you saying that supported living isn't a regulated industry in the way that residential homes and nursing homes are? You don't have to have a licence to set yourself up as a provider of supported living?

A. Again, I couldn't categorically answer that. I just wouldn't have the knowledge base.

DR. MAXWELL: But if they were regulated, it wasn't by the RQIA.

A. Correct.

DR. MAXWELL: And you're not aware, in the work you did, that they were being regulated by the Housing Executive or anybody else?

A. Well, Supporting People would have done quality assurance checks and other checks, and the provider may have been registered with other industry bodies.

DR. MAXWELL: But you're not aware which industry body that might be?

A. I'm not, I'm afraid. I don't have that knowledge base.

DR. MAXWELL: Okay.

201 Q. MS. TANG: Was that something that came up as a concern whenever you were engaging with families and with service users?

A. I can't remember that coming up as a specific element.

202 Q. Okay. Can we go down then to paragraph 23, which is on page 8, please? And this the addresses some of the attitudes to resettlement that you encountered, and you've made reference to them there; that the attitudes to resettlement and how this impacted the level and rate of resettlement programme and the process itself. Can you tell us who had these particular attitudes? 14:34 14:35

A. I suppose, again I'm just -- I would like just to reference back to the research methods. So we did a literature review, that was sort of the first theme; then we looked at the data, and then the third element was feedback from a range of stakeholders who are listed in the report. I suppose overall what we were picking up on was in some areas a reluctance to embrace the sort of theme of resettlement. That may have been service managers. We have noted elsewhere in the statement, obviously hospital staff at Muckamore may have been reluctant because of redeployment, and the union was involved in all of that. So we did get feedback on that element. And then in terms of family and parents as well, there was some feedback that there was a reluctance. They had felt that their loved one had been in Muckamore for a number of years, and so they had anxiety about this move towards resettlement. 14:35 14:35 14:36

203 Q. Do you think that those attitudes combined were highly

significant in the rate at which resettlement actually happened?

A. That is a difficult question to answer in terms of cause and effect. I think it would have had some impact on the rate of resettlement. 14:36

204 Q. Hmm. Can I ask you about a remark that's made in paragraph 24, which I think is over the page, and it's really just thinking about measuring betterment, and the diverse approach to measuring betterment, and to what extent it was actually achieved. Do you think 14:37 that the diverse approach to measuring betterment hindered the progress of resettlement across the country?

A. So, again, probably just to provide a bit of context. Betterment was mentioned by Bamford in 2002, and at 14:37 that point my understanding is there was three tests of whether betterment had taken place or not. Betterment was used as a sort of shorthand for improvements so that once the person was resettled they would experience this betterment, and it would be -- 14:38 betterment would have taken place if the individual, the resettlement was clinically appropriate for them; if it met their hands, whatever those range of needs were, and if it improved the patient's life.

Now, what we've commented on here was that each Trust 14:38 appeared to have its own approach to what betterment was, and we couldn't find any overall assessment of the criteria or how it was being measured. Now, one could suggest that you need a period of time before you

measure betterment. It would have to be longitudinal. But at the point of doing the research, we couldn't see what those sort of mechanisms were.

205 Q. So if I understand you correctly, were all of the Trusts measuring, to some extent, the experience of service users who were being resettled, but they just weren't measuring it the same way or -- 14:39

A. I wouldn't be knowledgeable to know if it was being -- if each were doing it. But our concern was that they all seemed to have their own approach to it. 14:39

DR. MAXWELL: Was there any evidence that the level above, the Department of Health or the inter-agency policy making level, had got any sense of how they were going to evaluate this policy? You know, resettlement is self-evidently a good thing in people's minds. 14:39

A. Mm-hmm.

DR. MAXWELL: Good social policy should have a measure of how effective it is surely, and did you find any evidence that the policy makers had a sense of how they were going to evaluate that? 14:40

A. I would say we didn't find evidence of that, and in part our second report, the 2017 Report, was to look at the impact of resettlement. So in the absence of anything else, that's what we did.

DR. MAXWELL: And the fact that there wasn't at policy level a set of criteria about what success looked like, did that make it challenging for you to do that, because if you don't know what the yardstick is, how can you measure? 14:40

A. It made it exceptionally challenging in that, as I've identified, betterment was under three areas, one of which was, was it clinically appropriate? And myself and John Palmer wouldn't have had any skills or knowledge to be able to say whether it had been clinically appropriate. We were focusing more on had it improved the patient's life.

DR. MAXWELL: The social aspects of their life?

A. So it was more a bit of social investigation, social research. But that, I suppose, came out of the fact that at the point of doing the research there didn't seem to be this joined-up process or thought pattern around 'Well, we've resettled these people. How are we going to measure if it was?' -- I mean I think success is different from betterment.

DR. MAXWELL: Okay.

A. And betterment is really an individual thing.

DR. MAXWELL: I meant success for the policy in betterment.

A. Yes. Yeah.

DR. MAXWELL: But, yeah, I take your point.

A. Yes. Yes.

DR. MAXWELL: Betterment is individual.

A. It's individual. And you could also extend it to the sense of individual betterment for the service user, but also for their family. So there's a ripple effect really there as to what does betterment actually mean.

DR. MAXWELL: And that's an interesting point, because we have heard from some speakers about how you use Easy

Read techniques to get feedback from the people themselves, but did you find anybody was actually asking the families, or was it either the professionals deciding or this feedback from the people themselves?

A. We wouldn't have any -- we didn't dig deeply in terms of knowing scheme by scheme or person by person, until we came to the second report, by which we developed a sample, and then we were the ones that were asking the service user, or the family, or the manager around betterment for that individual. 14:42

DR. MAXWELL: Okay.

206 Q. MS. TANG: Staying on that point, it's picked up to an extent in paragraph 26, which is further down that page. It refers to your 2017 Report, and that you didn't get a sense that the move had been traumatic or difficult for the people that you spoke to, the service users that you spoke to, I'm guessing? 14:43

A. Mm-hmm.

207 Q. Do you think that that reflects the population that were successfully resettled as much as anything else, that they might be slightly more straightforward in their needs? 14:43

A. So we spoke with 22 service users and/or family, and you make the point about is that reflective of the total population? In the report we referenced the difficulty that we encountered to try to get to a population that we could sample. And I want to make two comments on that: The first was that we had approached the five Health and Social Care Trusts at a 14:43

number of levels and in a number of ways, but the door was not opened for us to work through them. GDPR, confidentiality, other factors were mentioned. And so we then thought about and developed an alternative route, which was through the SP programme, and knowledge of schemes that people had been resettled to. There was about 80 individuals and we developed a sample of 25. So that's a sort of structural answer to the question. 14:44

The other element is that we were relying on, I guess to some level, the scheme manager to pick who we would speak with and so, therefore, there could be construed a level of self-selection around these individuals. But alongside that, we did aim and try to get a good representation around age, gender, geography, and different needs levels, in order to ensure that, for example, we had learning disability, we had mental health, we had some with forensic background, so that we weren't just focussing on one needs group. 14:45

PROFESSOR MURPHY: Did you interview anyone whose placement had failed?

A. No. At that point in 2017 those individuals were all in placements at that point in time. Whether that then went on to break down, but we didn't get access to anyone where there had been a failure. 14:45

CHAIRPERSON: Now, I just wonder what we can take from paragraph 26, because if the service user is broadly happy with the resettlement, it's obviously not going

to be one of those that failed. It's the people who aren't happy with resettlement that perhaps one needs to look at. Do you agree with that?

A. Yes, on the high level I would agree with that. I do feel we did get some valuable insights to the sort of discussion, because there was references to things like compatibility being a key factor, a key factor in success.

CHAIRPERSON: Yes.

A. And also the process of resettlement whereby, if I can just mention what was fed back to us was very much around initially maybe having a drive past a house or a place, then going for tea, then an overnight stay. So it was very much a planned progression, very much using story boards and using other methodology that would be very much used within the field of learning disability, you know photographs, pictures. So there was some valuable feedback.

CHAIRPERSON: You could certainly look at what good resettlement looked like.

A. Correct.

CHAIRPERSON: Yes.

A. Yes, yes. Yes.

208 Q. MS. TANG: I want to go back and drill a little bit more into a comment that you made whenever we first touched on this paragraph, where you had said that the Trusts didn't -- for whatever reason they weren't able to facilitate your research. Did you get the sense that there was -- the anxiety was all about data

sharing and things like that, or what sense did you get whenever you approached the Trusts?

A. Again recall might be difficult, it's ten years ago! I think there were just procedural things for them around not able to share data to let us know the addresses of people that we could then make an approach to. And I know at that point anyway each of the five Trusts had their research ethics process, it was different for every Trust, and we would have had to have gone through each of those. That would have taken, you know, quite a lengthy period of time. So because this was commissioned by the Housing Executive, we would have had constant reviews with them about the progress of the research, and the decision was taken to go in a slightly different way. 14:48 14:48 14:49

209 Q. I'm just thinking about the resettlements that didn't work out. Presumably if they didn't work out, the folks were still in hospital or in long-stay care of some sort, so is that something that was discussed whenever the research was being designed, about how do we find out and can we get an inroad into Trusts, for instance, to survey some of the service users and families of those folks? 14:49

A. As far as I recall that was not part of the Terms of Reference. I take the point that this is just the peak of the iceberg, whereas there could be considerable other issues below water. But, again, we were bound by the parameters of what we were being asked to look at. 14:49

210 Q. Okay. I want to take you down now to page 110-76,

please. It's in your first report at paragraph 2.6.4. And this deals with some of the, I suppose if I can call them practical aspects of people moving out of long-term care in hospital and into supported living placements or a community setting, and some of the practical things around their finances that have been flagged up there.

In the first paragraph, if you can see it in front of you there, I hope you can, about halfway down that first paragraph you use the term "population-wide funds rather than individualised accounts"; what are population-wide funds? What was that in practical terms? 14:50

A. So, this element of the 2014 Report, we noted with the Housing Executive, because in our opinion it fell slightly outside of the parameter of what we had been asked to look at, which was more to do with the housing and the housing support element. But as we had gone along, we had received comments about this. And this happens frequently within social research, that something that's outside the boundary of what you're looking at appears, and you note it. Population-wide funds, our understanding of that would have been that these were, for example at Muckamore, and that the funding was put into just a population-wide fund, rather than being kept specifically for that individual. 14:50 14:51 14:51

211 Q. So just so that I understand it; the funding itself, is

that the funding from the Health Board that the person in Muckamore originally came from? So a Northern Board patient who was in Muckamore, they would have ring-fenced funding that paid for their time in Muckamore, and then... 14:52

A. Yes, yes. Yeah.

212 Q. Followed them wherever they went next. So that was clustered, if I understand you then, for instance, as Northern Board funding rather than Northern Board funding for Mr. A or Mr. B, the long-stay patient? 14:52

A. So this would have been monies coming to individuals, obviously their support and their accommodation and everything was paid for at Muckamore, but they would have been entitled and would have been in receipt of some level of benefits. 14:52

213 Q. Okay.

A. So that was incoming money, or - and this was raised with us - they may have inherited a level of capital, and that would have been incoming against their name. But what we were being told was that that was not always held separately for them. 14:53

214 Q. I understand. So this isn't about the funding to pay for their package of care in the hospital, this is their own personal fund?

A. This is personal funds, which we felt, even though some of this was anecdotal, when we heard it, it gave us a concern. 14:53

PROFESSOR MURPHY: Isn't that financial abuse?

A. I think we felt that we had a concern and we wanted to

note it within the report.

PROFESSOR MURPHY: So did you escalate it anywhere?

A. It would have been noted and reported as part of this report with the Housing Executive who had commissioned the piece of work. 14:54

215 Q. MS. TANG: I noted at a point, I think it's the next paragraph, that for people who were leaving hospital there were key documents that some of them didn't have, and you mentioned passports, no national insurance number, and presumably those things then impact a lack 14:54 of ID document on their ability to register with various different, whether its benefits or supports. Did you detect in the planning process that there was any thinking that people would need these things, was that considered? 14:54

A. So again my analysis of this was that these items, thought patterns, were brought to us almost as a secondary element to the type of questions that we were asking. But, again, for us raised concerns about -- it's all very well talking about the resettlement 14:55 process, and getting accommodation, and a support package, and a domiciliary package and whatever else, but if the individual doesn't have access to their own funds and/or does not have the ID, the documentation, for example, to be able to move from the appointeeship 14:55 of Muckamore to the Trust, or if consent and if capacity was there, to open their own bank account, or to bank alongside family members, or whatever arrangement, we've noted here we felt that this

appeared to make the transfer of personal monies to personal accounts difficult.

216 Q. What I'm hearing is it sounds like this was just a hole in the planning process, that there hadn't been thought given to the fact that people would need these things when they left hospital. Is that a fair assessment? 14:56

A. I think because these were secondary comments given to us, rather than us exploring this in depth, I don't know that I want to go as far as that.

217 Q. Okay. 14:56

A. However, I do think that the anecdotal -- the analysis of this information does highlight an area that needs to be looked at.

218 Q. I want to move down, if I can now, to page 27 to paragraph 1.2, and this is where you have summarised some of your findings, and it picks up on something that we had started to speak about earlier around the research finding no evidence of a joint resettlement plan and commissioning strategy. I want to reflect on that in terms of the way failed resettlements were potentially not analysed; do you think, whenever you reflect back on it, had there been an overarching body or some sort of big plan that was being driven, would we know more about failed resettlements and about what made the difference? 14:56 14:57 14:57

A. I think the lens of hindsight, even sitting looking through this today ten years on, would highlight a number of aspects around the need for that overarching resettlement plan that would have welded together the

different statutory and voluntary sector. I mean a lot of this is delivered within the voluntary community sector. So that overarching plan. But alongside that, as previously mentioned, the need for things to be monitored, regularly, consistently, against agreed 14:58
targets and aims, and then evaluated. So since the 2017 Report that myself and John Palmer did, within quite tight constraining factors, I'm not sure how much has been done to evaluate, No. 1 the final levels of resettlement from Muckamore and/or the concept of 14:58
betterment, with a particular focus on two aspects: No. 1, where it's been a success, but as pointed out today, where it hasn't been successful. Because a failed placement means that that individual may have to move back to Muckamore or somewhere else and/or move 14:59
into another placement, which, again, the impact on the individual of that would need to be taken into account.

219 Q. Mm-hmm. In terms of what actually was put in place by way of supported housing, it does sound as if a substantial proportion of the provision was actually 14:59
nursing homes, or facilities like that. Do you think that that -- do you think was there actually quite a limited range of options for people in terms of the community placements that they could go to?

A. I can't categorically say that the majority were 15:00
nursing homes.

220 Q. Sorry, a substantial proportion I think was what I mean?

A. A substantial proportion. But alongside that there was

a high level of bespoke facilities that were built and were provided, and then one-to-one, two-to-one, three-to-one, you know, support ratios for people. Again, supported housing is another area that we could talk about in terms of what the overall strategy is for that. Sorry, I've probably drifted from the question.

221 Q. No, that's fine. I think it's really just thinking about the options that were available for people and whether there was a degree of flexibility built into that. So, for instance, if someone had wanted to live with their family but needed a bit of support, or maybe some adaptations and things, did your research look at the amount of flexibility that was available to them?

A. We wouldn't have gone into that level of depth. We were more looking at the process of resettlement and how that occurred.

222 Q. Okay.

PROFESSOR MURPHY: But, for example, that kind of support would be called "personal budgets". Did you come across any evidence that there were personal budgets being used given to families to purchase the care to support their person at home?

A. We wouldn't have gone into any depth on that particular item.

223 Q. MS. TANG: Thank you. Can I pick up on a figure, a financial figure that you have made reference to, which is on page 110-30 at paragraph 1.7, please. I'll find it here, I think it's possibly further down the page. Yes, there we are. Thank you. It's just the second

paragraph from the top of the screen there that you can see, the mean contract value is referred to in the second sentence of that paragraph:

"The mean contract value was approaching £109,000 per annum..." 15:02

- I just wanted to clarify with you, is that an average cost per year of a resettled person or is that not what that means? 15:02

A. I'm afraid I would have to go back to the research to make myself sure and clear that that is what that means.

224 Q. Okay.

A. Apologies. 15:02

225 Q. Okay. Thank you. Right. Moving down, if I can, now to page 31, and paragraph 1.8, just towards the end of your summary of your findings. You had referred to providers being rated for risk, I think it's actually further down in that paragraph, if we could move down 15:03 to the next page. Yes, that's fine. Thank you. The lower paragraph on your screen at the moment talks about providers being assessed as medium risk, and one was assessed as high risk. Can you explain to me, if you can, how were providers assessed for risk? 15:03

A. Again I have to say apologies. One of the factors in doing a bit of research jointly with somebody else, these would have been John Palmer's areas of expertise, and if a follow-up is needed on those elements,

I'm sure John would be happy to input.

226 Q. Okay. Thank you. Okay. Right. I want to pick up on some numbers here, and I hope that will be all right. It was just to clarify with them, page 47, please, and it is a number that's referred to in Table 9 -- oh, 15:04
sorry, it's figures in general in Table 9. I'm trying to work out what's included in these. So I suppose just to -- if you can have a look at Table 9 there? I wanted to ask you does that include the costs of all the placements, so that means all the staff, and 15:04
anything that goes with providing care to these men and women with learning disabilities, or what's included in those figures, to your knowledge?

A. So those figures were provided by the Health and Social Care Board based on what was provided by the five 15:05
Health and Social Care Trusts, and that would be their ongoing revenue costs in relation to care within the services that they were then providing for people that were resettled.

227 Q. So if I understand that correctly, this is about people 15:05
who were no longer living in hospital and this is what it was costing to keep them somewhere else?

A. Yes. Yes. Correct.

PROFESSOR MURPHY: But then why does it say no resettlements for some of the Trusts? Because that's 15:05
still costing them money, isn't it? There are still people who have been resettled who are costing them money. I don't see how that can be nothing.

A. So I see that one of them was for the Western Trust,

and all of the resettlement had been completed by 2012, is my understanding, at Gransha. And then the other one, the Southern Trust, was in relation to Longstone. Again, by then all of the -- so these would be figures for people coming into the resettlement then.

228 Q. MS. TANG: So this is what was --

PROFESSOR MURPHY: So it wasn't really that they were costing nothing, it's that they couldn't provide the figures?

A. No, I think it possibly relates to the process of resettlement and that in those particular years there was nobody resettled from those two Trusts where it says "no resettlement".

DR. MAXWELL: So this is the cost of the act of resettlement and not the ongoing cost of paying for them when they are in?

A. Yeah. Again, I think we would need to clarify that.

CHAIRPERSON: It's obviously not what the heading says, is it?

A. Yeah.

CHAIRPERSON: "Learning disability care costs"?

A. "For the resettlement programme". So my understanding would be that that's people coming into the resettlement programme.

PROFESSOR MURPHY: I think we probably need to clarify that.

A. Clarify that.

CHAIRPERSON: Yes.

DR. MAXWELL: Well the second column is projected,

isn't it? Because you've got the actual costs, 2012 to 2014, and the projected costs are '15 onwards? But I'm just wondering, it therefore seems to me it must refer to the act of resettlement and not the ongoing cost of paying for their care once they're living somewhere else.

A. Okay. I can clarify that through yourselves.

MS. TANG: Yes, that would be helpful.

DR. MAXWELL: Yes.

CHAIRPERSON: Thank you. 15:07

229 Q. MS. TANG: Staying on some of the costs associated with placements, if we could go down to page 51, please, and the paragraph I want to look at is 2.3.4. I just wanted to ask you to clarify, if you would, please, a comment that you've made there. I wanted to ask you about the cost per placement and the fact that some of the earlier placements seem to be less complex. Were they costed too highly? Is that what you were saying? 15:08

A. I'm not sure that I understand the question.

230 Q. Okay. I'm just looking down through -- if I can get you the -- yes. Do you see in the last very last paragraph of your paragraph there, it's in bold: 15:08

"...the figures were announced publicly at the outset of the programme so that Trusts commissioning in-house services, and independent sector providers, were given clear guidance on the prices they could charge. Interviewees said that this has meant that the intended 'swings and roundabouts' in which cheaper services

commissioned early in the programme would allow funding for more expensive services commissioned later were not achieved."

What does that mean? 15:09

A. My understanding is and my recall is that earlier in the programme when people were being resettled who had lower care needs, less complex, that was deemed and was evidenced to be cheaper, and there was the thought pattern that therefore if that was cheaper, that there 15:09 would then be savings built in that could be utilised later in the resettlement programme for folk with more complex chronic needs.

231 Q. So is this thinking then that there was an indicative average cost per person? So someone who needed a 15:09 simpler package, this would be a cheaper cost, there would be more money left for the more complex?

A. Yes. Yes.

232 Q. But that didn't then materialise?

A. Well I think then as time progressed -- so, for 15:10 example, on the previous page, you can see there that the cost of, you know, a very high unit cost for some of the bespoke services, because of the nature of the actual capital build, but then the level of staff, staffing ratio, would have been much higher than 15:10 anticipated.

233 Q. Do you think, and I appreciate your research may not have covered this, but was there a failing in the planning that there hadn't been an anticipation of the

fact that this was going to cost much more than first thought?

A. I think hindsight again gives us that lens where we can review and say, 'Yes, we should have known'. But at the time people were being assessed bit by bit. So you may not necessarily have known what was coming down the pipeline in terms of the level of need, the complexity, the geography, and also at times we need to just recall, you know, the changing build costs, the changing costs of land. So I'm not sure that we can completely say that all of this could have been factored in right at the very outset. 15:11 15:11

PROFESSOR MURPHY: But there was a lot of experience, for example in England, of closing big hospitals, you know, years and years before this. Did they not consult with any of those counties, for example, about their experience? Because this is exactly what happens whenever you close a big hospital, isn't it? 15:11

A. Yes. I actually have no knowledge of what level of contact was made or lessons learned. I'm not sure if there was actual practical learning in that way by Muckamore or by those delivering the resettlement programme. 15:12

MS. TANG: Chair, I'm mindful of the time. I am going to take the witness to her second report shortly? 15:12

CHAIRPERSON: Yes. Okay. Well, should we take a break there because you've probably got another hour to go.

MS. TANG: I think it would be shorter than the first. I think probably the biggest part done.

CHAIRPERSON: Okay. We'll break there. We'll take a ten minute break and then we'll come back. Thank you very much.

A SHORT ADJOURNMENT 15:12

THE HEARING RESUMED AFTER THE SHORT ADJOURNMENT AS FOLLOWS:

MS. TANG: Thank you, Chair. 15:28

234 Q. Hello again. I want to turn now to your second report, the one that was published in June of 2017, and the page where that begins is 110-107. And we've spoken already about the sample of people that you were in contact with to conduct that research, and that these 15:28 were people who essentially had managed to be successfully resettled. Whenever you were speaking to the service users themselves, or their families, did you get the sense from any of them that there were some, in some ways for some of them, that life was 15:29 actually somewhat worse out in the community than it had been in the hospital?

A. Perhaps I can refer to elements of the report which reference that, and what we would call them would be limitations or barriers to betterment. So the overall 15:29 aim was to have betterment through resettlement and being out of a large institution. But there were a number of things that service users and family members mentioned. For example, the location of the

accommodation, lack of access to services, lack of access to transport, and because I was going out to do the interviews, I was able to see where people were, and even in my own mind I was able to think, well, that's quite far from any bus stop and access to transport to be part of a community.

Another element that people very much touched on was that within, for example Muckamore, there had been activities, and they maybe had a lack of access to daycare places within the community once they had been resettled. 15:30

235 Q. So whenever these observations were made, did you get the sense that these were unforeseen or unexpected, or was it that something had been put in place and it just hadn't worked out. So, for instance, daycare activities and things? 15:30

A. My opinion on that would be, not based on the research, would be that when you're in the community the actual level of access to services such as those can be quite limited. Either funding means that there isn't the number of daycare spaces, day centre spaces, or the availability or proximity of it, the frequency of it. So, again, I'm not sure if in an overall resettlement plan that could have been foreseen for each individual. 15:31

236 Q. So was it, in your understanding the resettlement plan, would there have been that kind of detail such as; how is this person going to get to the shops? How is this person going to go see their friends? Was that -- did 15:31

that appear to have been considered whenever they were placed in maybe quite rural settings or whatever it be?

A. Our understanding would be that, yes, that was part of the operational planning for resettlement, that it wasn't just about moving somebody from Place A to Place B, that all these other factors, there was the suitability of the actual accommodation, but if we are talking about betterment and that move towards community living, then, yes, access to services, access to family and friends, access to transport, would most certainly have been part of the equation. 15:31 15:32

237 Q. But did you get the sense that it had always been fully considered, or the fact that some of these folks experienced difficulty with these things, does that tell us that it may have been overlooked in some cases? 15:32

A. Just to refer back to I suppose my previous answer, is that I'm not sure that in a Northern Ireland sense we can tick all of those elements off, because, you know, quite a big proportion of the population aren't near a bus stop or near day centres. So, you know, I think there were other factors occurring around this. 15:32

238 Q. Does it strike you as something that given that this is a somewhat more vulnerable population coming out though that in the planning processes there really should have been more thought given to the social settings and the options that those would leave people to interact, or to get out and about and to live independently, is that a failing? 15:33

A. Yes. So I think in terms of betterment, what we were

able to witness to see, to record, was this element of privacy, their own space, they weren't in a ward, their activities within the household or the scheme. But as I've noted, the limitations to betterment would be this wider aspect of being part of the community. Part of that for some individuals, as we've noticed, as we've noted, was related to their care and support needs, that it may not have been practical or possible for them to be within the wider community.

239 Q. Mm-hmm. 15:34

A. And another factor, just to mention, would have been, and I witnessed this in a couple of cases, was neighbourhood issues. So, for example, there was a desire that this -- I can think of one three-bed unit, just within an ordinary neighbourhood, and there had been a breakdown of relationships with the neighbours, to the point, for example, we've noted in the report, that staff members were being hounded about where they were parking, or complaints were being made about the service users being in the back garden and making noise. So those elements of potential betterment within a community setting, we could conclude are quite difficult. That was in just a small number of cases. I couldn't comment on how much that occurs.

240 Q. So would you say that is -- was that 10% of the sample that you saw or a bigger number than that? You say a small number. 15:35

A. I couldn't put a percentage on it, but we did recognise it in some settings.

241 Q. Okay. For the people that you spoke to, or their families, how long roughly had they been in the resettlement process? Was there an average amount of time that it took for them that you can recall?

A. That varied considerably and, again, related to a range of factors. It would on the one hand have related to the assessment process of the person in Muckamore, but also then it related directly to the availability of suitable accommodation. 15:35

242 Q. And did any of the people that you interacted with in that sample, had they had any failed resettlements or had it all gone smoothly for them, that you know of? 15:36

A. As far as I recall it was a smooth process, and that then has produced the result that people were content with how it had occurred. 15:36

243 Q. I want to go to page 112 of your second report, and its where you have listed some of your findings. I'm just going to turn it up here. There were a number of factors that you had observed there in summary. Drawing on some of the conversations you had with family members particularly, so the bullet points begin there just about -- just near the top of the page. So a small number of family members identified some concerns around safety for a small number of resettled people, and uncertainty on the part of the family about whether the resettlement was appropriate for their relative. Would that have been around things like location, or was that more about whether this building was safe for them, or what kind of issues were they 15:36 15:37

concerned about?

A. Yes. It would have covered both of those items that you've mentioned. I think there was -- we did pick up from family members that level of, you know, at the time of resettlement and going through the process that they had voiced concerns. Because of the length of time that their family member had been in Muckamore, and because it was familiar and they knew what the set-up was, they had concerns about 'Well, how will they resettle in the community?', and I suppose they were maybe concerned about 'Will this work out? And if it doesn't work out, what will happen?' 15:37 15:38

244 Q. Hmm. You go down -- the next set of bullet points you mention some other concerns that family members raised about the process, including a lack of parental consultation and involvement. Was that on the back of their concerns that they had in not feeling listened to or was there something else about the lack of parental consultation? 15:38

A. I think that was just a general comment by a number of family members related to the one below which was this sort of stop/start approach. And that very often was linked back to what accommodation or what supported housing was available. So sometimes we would, you know, have had stories given to us that accommodation had been identified, and so then it was all that process again of working towards it, and then for whatever reason that accommodation wasn't appropriate, so it sort of stopped again. So I think the 15:38 15:39

consultation and feeling involved was sort of on and off, and not feeling that they had been adequately asked or involved in the process. Now that was a smaller number of family members noted that.

245 Q. And is that process, does that include the assessment of the person's needs, what it would take to keep them safe or happy and enjoying life, all of that? 15:39

A. There's all of that, and then also looking at what appropriate accommodation, and that again comes back down to location, how many people will be there, what type of service? So there's so many factors that the parents or other family members had to think about. 15:39

246 Q. Mm-hmm. Was it a common observation by parents that they felt that the accommodation on offer just wasn't appropriate? 15:40

A. I wouldn't say that. I don't think that was a conclusion that we drew.

247 Q. Mm-hmm. Was it voiced by some or very few?

A. I think a small number would have felt there was, you know, a lack of variety or a lack of diversity. 15:40 I suppose there were so many factors again to knit into the whole process. You might have been satisfied with one element of it, but would have liked something else. And, again, we're putting it in the context that the majority of people were moving from a ward setting 15:40 where really they had a bed with a bedside cabinet, but the betterment was that they would have an individual room, and that then the elements of privacy, and choice, and personal furnishings would be part of what

they were being offered.

248 Q. I want to move down to page 129, because it picks up on some very, very specific examples of big change and betterment. If we could look at paragraph 53, and it refers here to: 15:41

"In one case, a female service user had been given an enema on a weekly basis whilst in Muckamore..."

And:

"...when she came out this stopped because her diet had changed..."

And that she was getting:

"...more 1:1 attention in terms of her medical and health needs."

Then in paragraph 54 there is a description of the 15:41 sister of a service user who didn't realise that her brother could walk, because every time she saw him he was in a wheelchair at Muckamore. When you were conducting this research, were you aware that there had been some safeguarding issues flagged up around 15:42 Muckamore?

A. I think at the time of the research back in 2016/17, I can't recall if there were safeguarding issues at that very point.

249 Q. Do you recall having any awareness of safeguarding issues then, or am I hearing what you're saying to be you weren't aware?

A. I can't honestly put it into the time span, now knowing as we do now that there were safeguarding issues. 15:42

250 Q. Okay. Well when you spoke to these patients, or these family members who described these things, did you have concerns about the standard of care that they had had that they were describing?

A. I think these two examples are quite stark. They show 15:42 that the before and after. In the first case, that a medical intervention was potentially being used that was not necessary once the person was in their resettled accommodation with a different approach, and as we mentioned earlier about the medical approach 15:43 versus the social approach. And I think the second one again is quite stark. I mean I think when you're hearing this from people and you can see their emotion, and hear their emotion, and to know that actually when they're then resettled they don't need a wheelchair. 15:43 So in your mind's eye you might be concluding that it was potentially easier to put this individual into a wheelchair.

CHAIRPERSON: Could I just ask how these quotes were obtained, as it were? Was this direct evidence to you 15:44 personally?

A. Mm-hmm.

CHAIRPERSON: So you heard this. Were they recorded interviews?

A. No, they were the not recorded as far as I recall.

CHAIRPERSON: You were making notes?

A. Yes. So this would have been through either one-to-one interviews, or there might have been maybe two parents present, or a service user with maybe a member of staff in attendance. 15:44

CHAIRPERSON: And can you remember before you published your report whether you confirmed the accuracy of these with the giver of the statement?

A. Well, in one sense that is done at the time of the interview, where when we're speaking with the individual we would clarify and we would check. 15:44

CHAIRPERSON: Okay.

A. And, again, just being quite sensitive to the level of understanding and the level of questioning with people in this type of research. 15:45

CHAIRPERSON: Sure. No, I do understand that and I'm not being critical, but I just wanted to understand when we read these they are your direct, as it were, evidence in relation to things that you were personally told. 15:45

A. Absolutely.

CHAIRPERSON: Okay. Thank you.

251 Q. MS. TANG: You obviously documented these in your report, but can I ask did you do anything in addition to that to flag up or to alert to these potentially very poor standards, did you escalate that or do anything else? 15:45

A. I did not.

252 Q. Okay. My final question for you is: These reports were both commissioned by the Housing Executive. Do you know what they did with them? Did they share them with anyone in the first case?

A. Well, both reports have been published and would be publically available and would be on the Housing Executive website. In terms of what specifically they have done as follow-up, I couldn't comment on that. 15:45

253 Q. Were you aware whenever the Housing Executive commissioned these reports, did they tell you how they intended to use them or what they were hoping to be able to do to with them? 15:46

A. I suppose it's like any piece of research; the researcher does the bit of work, it goes to publication, and then it's up to the individual commissioning body to decide two things: No. 1, how do they disseminate it and, No. 2, how do they use it? 15:46

254 Q. In the case of both reports, did they accept your findings?

A. I would agree that they did in the sense that they are both published as is, as they are in front of you today. 15:46

MS. TANG: Yes. Okay. You've answered all of my questions, but I'm going to hand over to the Panel in case they have any residual ones that they want to pick up with you. 15:47

A. Thank you.

MS. BOYLE WAS THEN QUESTIONED BY THE INQUIRY PANEL AS

FOLLOWS:

255 Q. PROFESSOR MURPHY: I did have one question for you, which was, did you talk to the advocacy organisations at all?

A. No, we didn't. And somewhere in one of the reports I made, or we concluded, at the time, 2014 and 2017, the term "advocate" was starting to be used, but it wasn't particularly well developed, and I recall in a couple of the schemes asking was there an advocate and the answer was "no". So I think that maybe came post 2017.

256 Q. PROFESSOR MURPHY: Yes, possibly. One of the reasons I ask is that one of the witnesses we had from Bryson Care said that they were collecting data on betterment, but it sounds like you didn't ever come across this?

A. Did I come across Bryson?

257 Q. PROFESSOR MURPHY: Did you come across their data on better -- well, first of all, did you come across the organisation, but then did you know they were collecting data on betterment?

A. I didn't know that they were collecting data on betterment. I think they are potentially listed as one of our, or they were maybe listed as a provider within the report, but I can't recall any exchange with them on that.

PROFESSOR MURPHY: Thanks.

CHAIRPERSON: Any?

DR. MAXWELL: No.

258 Q. CHAIRPERSON: Just give me a second. Sorry, I'm just trying to find a reference. Yes. You were asked about this I think by Dr. Maxwell. If you go back to page 27 of the first, it's page 27 of our bundle, page 9 of your report, you were asked effectively whether Northern Ireland has a similar or a higher preponderance of those with learning disability than on mainland Great Britain.

A. Mm-hmm.

259 Q. CHAIRPERSON: And what you were talking about here was the number of those who are actually in hospital, or you had been dealing with those who had been in hospital and there was a higher preponderance of those in Northern Ireland?

A. Yes. Yes. Yeah.

260 Q. CHAIRPERSON: Then you look at Prof. McConkey's work, and he counted more than 40,000 people who were identified by the member of the household completing the census as having a long-term learning, intellectual, social, or behavioural difficulty. You say:

"The Census figure is more than double the number of learning-disabled people derived from a study of health and social care records by Prof. Roy McConkey et al in 2003 on which the Bamford Review and the development of subsequent policy was based."

And you say:

"This difference is not accounted for by estimates of the rate of change in the number of learning-disabled people in Northern Ireland."

But then you say:

"McConkey et al had serious reservations about the accuracy of the health and social care data available to them on which their estimates were based."

Does that affect the numbers used by Prof. Bamford?

A. I think what we were suggesting was that it did. But that is, I suppose, in the wider population, and I suppose what I've focused on here today is more the numbers within Muckamore. 15:51

261 Q. CHAIRPERSON: Yes.

A. Rather than the wider population.

262 Q. CHAIRPERSON: So we've really got to be careful at taking any of that data in relation to the wider population? 15:51

A. Yes.

263 Q. CHAIRPERSON: Because it may not be accurate?

A. Yes. Yes.

CHAIRPERSON: Okay. 15:51

264 Q. DR. MAXWELL: So you're suggesting any difference between Prof. McConkey's and the population centres isn't relevant because this would be at the milder end and unlikely to be in Muckamore?

A. Correct. I think it was providing context for the report looking at the population of learning disabled people, but I think for this Inquiry it's much more focused on Muckamore and who was there.

CHAIRPERSON: Yes. No, understood. I just wanted to get your clarification on that. 15:52

Can I thank you very much for giving up your time this afternoon, it's been very helpful, and you can now go with the Secretary to the Inquiry. Thank you. 15:52

A. Thank you.

CHAIRPERSON: Can I just mention that the statement that was summarised and referred to this morning by Ms. Kiley, which is that of Elma Newbury of the Northern Ireland Housing Executive, is now up on the website. So again with our apologies that you didn't have it earlier, it is there now. And we will meet again tomorrow morning at ten o'clock. Thank you very much. 15:52

15:52

THE INQUIRY WAS THEN ADJOURNED TO TUESDAY, 25TH JUNE 2024 AT 10:00 A.M.