MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of John Veitch
Dated this 23 day of February 2024

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

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

1. I have been asked to make a statement for the purpose of the Inquiry's examination of the Ennis Ward Adult Safeguarding Report. I have specifically been asked to address ten questions and I now set out my responses to those questions in sequence.

Q1. What was your job title and role in November 2012, the time of the allegations which gave rise to the Ennis investigation?

2. I assumed the position of Co-Director for Children and Adult Learning Disability Services working for the Belfast Health and Social Care Trust ("the Belfast Trust") at the beginning of 2011. I had a brief lead in period with the previous post holder for Adult Services, Miriam Somerville, who retired during March 2011. I remained in this post until my own retirement in September 2016.

3. In total, I was employed in health and social care services in Northern Ireland for thirty-nine years. I am a qualified social worker and held numerous responsibilities for social work and multidisciplinary services at practitioner and various management levels throughout my career. The position of Co-Director

for Children and Adult Learning Disability Services was not a designated social work role, but was open to those from a range of graduate and professional backgrounds.

4. As Co-Director, I held responsibility, through the Director of Primary and Social Care, being initially Bernie McNally and then Catherine McNicholl from mid to late 2012, for all aspects of the management and development of an extensive range of community and hospital services. This included inpatient services to five local community Trusts for children and adults located at the Iveagh Centre and MAH respectively.

5. On my appointment to this post, a major challenge was to oversee the management of the discharge to community placements of one hundred and eighty-two inappropriately placed adults from all five community Trusts who were in MAH. This was accompanied by the attendant closure of resettlement wards which was required to substantially fund the alternative community care placements. It also required the continuing effective management of those patients remaining in MAH and managing the significant human resource implications both for staff and the Belfast Trust.

6. As Co-Director, the overall services which I managed had four components. each with individual senior service managers reporting directly to me. Namely;

- Children's Community Disability Services. The senior service manager in this area was Pauline McDonald. These services transferred to the Children's Directorate around April/May 2013.

- Adult Learning Disability Residential, Supported living and Day Services. The senior service manager was John McCart, followed by Margaret Cameron, William Morrow and then Neil Kelly.

- Adult and Children's Inpatient Services at MAH and the Iveagh Centre incorporating the role of Associate Director of Nursing and Learning Disability Services. The senior service manager was Eilish Steel up to late 2011, followed by Esther Rafferty from January 2012.

- Adult Learning Disability Community Teams and Treatment Services incorporated the role of Associate Director of Social Work from Barney McNeaney's appointment. The senior service manager was initially Petra Corr, followed by Barney McNeaney, and then by Aine Morrison.

Q2. When and in what circumstances did you first become aware of the allegations?

7. I first became aware of the concerns reported on 08 November 2012 in relation to Ennis Ward on my return from annual leave on 28 November 2012.

Q3. What actions did you take on first becoming aware of the allegations?

8. I recall that I was initially briefed separately on this development and the subsequent actions by Catherine McNicholl, Director of Adult and Primary Social Care; Esther Rafferty, Senior Service Manager; Aine Morrison, Operations Manager and Designated Officer for the Ennis Investigation; Mairead Mitchell, Senior Governance and Service Improvement Manager for Mental Health and Learning Disability Services (who reported directly to Catherine McNicholl) and Moira Mannion, Co-Director for Nursing, Education and Learning.

9. I was appraised of the immediate action taken on receipt of the initial seven allegations made by a care assistant employed by a private provider which had been working in partnership with the Belfast Trust, Bohill Care Home ("Bohill"). Specifically, I was advised:-

- That full details of the information received by the Belfast Trust were immediately shared with PSNI and RQIA.

- That an early alert form was completed and submitted thus notifying the Department of Health, the Health and Social Care Board and the Public Health Agency.

- That two members of staff and a student nurse were placed on precautionary suspension. The Belfast Trust's employees were a healthcare assistant and a bank nurse who were also referred to the disclosure and barring service and nursing and midwifery council respectively.

- That the Belfast Trust appointed Aine Morrison, Operations Manager, to the role of designated officer for the adult safeguarding investigation and she had convened and chaired two multiagency strategy meetings on 09 and 15 November 2012, which included the participation of Police and RQIA representation.

- That the relatives of the four patients identified were promptly notified of the reported concern and of the action taken by the Belfast Trust. It was further reported at the meeting held on 15 November 2012 that the relatives of all other patients at Ennis had been notified and provided with contact details for both inside and outside the hospital.

- That the immediate protection plan included twenty-four hour monitoring on Ennis Ward through the deployment of an additional band 7 nurse from outside the ward during the day and a band 6 nurse during the evenings for monitoring purposes. Arrangements were also made for band 8A members of staff to make frequent unannounced visits to the ward also for this purpose.

- That body charts were completed for all patients on Ennis Ward.

10. I shared the concern of all senior and operational managers involved regarding the nature of the concerns reported and particularly the circumstances of the referral from staff of a partner agency working within the Ennis Ward.

11. As Co-Director, I had responsibility for safe and effective care across all services. I therefore had a primary and overriding responsibility to patients/service users and their families but also a complimentary responsibility to appropriately support and value staff.

12. The Ennis investigation represented a response to serious reported concerns and therefore required the significant attention of senior management, effective processes to ensure oversight of progress and developments as the investigation progressed and an appropriate and timely service response. This degree of concern is reflected in the minutes of the initial strategy discussion held on 09 November 2012 which state "*the allegations were of significant concern, both in relation to individual reported incidents and a potential culture on the ward...*" contained in page 6 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry.

13. As noted above, an immediate and comprehensive protection plan was put in place including the deployment of the additional band 7 and band 6 staff as monitors. Whilst action had already been completed in fully informing the families of the four named patients, it was further agreed at the meeting on 09 November 2012 that the families of all other patients on the ward should be notified of the investigation.

14. I was also appraised of and assured by the immediate action taken by the Directors of Nursing and Adult Social and Primary Care, Brenda Creaney and Catherine McNicholl in promptly commissioning Moira Mannion who was independent of the MAH service to lead and coordinate intensive monitoring arrangements on Ennis Ward and to:

- Complete ward observation of staff behaviours and patient care.
- Complete unannounced leadership visits.
- To lead the team of monitors engaged in the monitoring activity.
- To review all monitoring reports submitted.
- To report on actions completed.
- Provide an improvement plan to Catherine McNicholl and Brenda Creaney.

15. Additionally, RQIA had undertaken an announced inspection of Ennis Ward on 13 November 2012, in response to which the Belfast Trust had provided a quality improvement plan on 20 November 2012. The plan outlined comprehensive action being taken to address staffing deficiencies by increasing staffing levels and monitoring arrangements. It also included actions relating to vulnerable adult governance arrangements and the review of individual protection plans.

Q4. What was your role in the Belfast Trust's safeguarding investigation into the allegations made about incidents on Ennis ward on 08 November 2012? It is anticipated that the answer to this question will include, but not be limited to:

- **A detailed explanation of your specific role(s) and actions taken;**
- **If you worked with others, an explanation of who they were;**
- **An explanation of who you reported to in respect of any actions.**

16. I ensured that I was kept fully appraised of the progress of the vulnerable adult investigation including discussions and decisions taken at the formal meetings held on 12 and 20 December 2012, the outcome of RQIA inspections and improvements being planned. In reviewing the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, I note in the meeting held on 20 December 2012, the minutes demonstrated that Aine Morrison was consulting with Cecil Worthington, the Executive Director of Social Work and John Growcott, Co-Director for Professional Social Work, therefore demonstrated a direct line of professional accountability which is required for any adult safeguarding investigation.

17. I was also aware of Moira Mannion's briefing report dated 19 December 2012 which summarised the actions completed in accordance with her monitoring brief and the issues identified. It specifically highlighted that eighty-five monitoring forms had been submitted over a five week period by twenty independent senior nursing staff reflecting eight hundred and forty hours of observed practice over a twenty-four hour cycle.

18. This report of 19 December 2012 also specifically noted continuing concern regarding staffing levels and environmental issues but monitoring also had demonstrated best practice and positive interaction by staff with patients. It concluded that there was "*no indication of any possibility of a culture that may be accepting of behaviour or communication that could be referred to as abusive,*" contained in page 87 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry.

19. I recognised the extensive range of issues being considered by the investigation and from January 2013 I attended all adult safeguarding meetings/case discussions. This reflected my role and responsibility as Co-Director for safe and effective care on Ennis Ward and the nature and extent of the reported concern.

20. Belfast Trust management up to Director Level, Brenda Creaney and Catherine McNicholl were aware from an early stage of the impact of the investigation on

patients, staff and the operation of the ward. I reported to Catherine McNicholl and Moira Mannion reported to Brenda Creaney. While I would meet Catherine McNicholl on a monthly basis there was frequent informal contact regarding progress and developments.

21. Within the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, I have reviewed the notes/minutes of strategy discussions which I attended and wish to highlight a number of issues with particular reference to comments attributed to me on 09 January 2013.

22. In item 3 of the minutes of the meeting on 09 January 2013 which appear at pages 52 – 61 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, on reviewing the document entitled "*list of allegations*" which appears at pages 386 – 393 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, I did not regard this as an accurate description of the content of this document and considered it important that I raised and clarified this at the strategy meeting. Whilst numerous points in this document represented specific allegations, others were comments which required clarification in the first instance before being categorised as a specific allegation. Others seemed to be negative, nonspecific comments. Whilst not disregarding any of the issues highlighted in this document, it was important that the primary focus of the vulnerable adults investigation remained on the specific safeguarding reports made on the 08 November 2012 and those reported subsequently. This would remain the subject of review as any new information emerged.

23. Also, in relation to item 3 of the minutes of the meeting on 09 January 2013, there was no suggestion that Esther Rafferty (service manager for MAH) was implicated in any of the reported concerns. While aware that MAH staff had been excluded from attendance at earlier strategy meetings, I considered it important and appropriate that Esther Rafferty should attend all investigation meetings to provide information and be able to respond to any emerging issues

of concerns. This was particularly important in relation to discussions relating to the environment and operation of the ward such as pressures related to staffing and other regulatory concerns highlighted during the investigation.

24. In item 6 of the minutes of the meeting of 09 January 2013, which appear at page 58 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, the issue of the investigating team having access to photos of Ennis Ward Staff was raised and highlighted the primary responsibility for safe and effective care whilst respecting the rights of staff. These photographs are held at Belfast Trust level in the human resources department. I recall that advice was sought from the Belfast Trust's human resources department. I cannot recall if I spoke to them or I asked someone else to speak to them and it was the advice of human resources that is reflected in my comment at this meeting, that the use of photographs could only be used as a last resort. I also advised the investigating team to seek advice directly from human resources regarding the investigation including access to staff's personal information. This was actioned by email on 24 January 2013 by Yvonne McKnight (Corporate Adult Safeguarding Officer) in response to which legal advice was sought by the Belfast Trust's human resource department and a full response was provided on 31 January 2013. I attach a copy of this email exchange at Exhibit 1 of my statement. On reviewing this email exchange, I note the issue of access to staff photos is not pursued in this correspondence from Yvonne McKnight on 24 January 2013. It was however agreed that I should meet with Barney McNeaney and Aine Morrison to further discuss this issue and this is referenced in the minutes of the next meeting held on 23 March 2013, which appear at page 63 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry and confirm that this meeting took place and it had been decided not to use photographs of staff at this stage to make identifications. No objection is noted or recorded to the course of action agreed.

25. Also at this meeting on 09 January 2013, Moira Mannion's further briefing report of 09 January 2013 was considered and was the subject of extensive discussion. This detailed nine page report was only available on the morning of

the meeting and summarised the outcome of extensive consultation, reviews of patient's records, medical files and Kardex medical reports. It referenced the outcome of one thousand five hundred and nineteen hours of observed practice, quoted from one hundred and eighteen monitoring forms highlighting extensive and significant evidence of positive practice alongside continuing issues related to staffing and maintaining the environment. Whilst highlighting the importance of progressing the improvement of the ward environment and completing the investigation as quickly as possible, it also concluded in this report that there is "*no evidence that there is a culture, tolerant of behaviours that could be defined as abusive or support systemic abuse*," which appears at page 95 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry. Reference is also made to reviewing compliance with MAPA training, a recent audit of this, personal life story book work with patients and Moira Mannion's discussions with MAPA and ergonomics trainers. The total cost to the Belfast Trust of the additional monitoring arrangements was approximately £500,000 in addition to a budget which MAH already had significantly overspent. This demonstrates the seriousness with which the reported concern on 08 November 2012 was regarded and responded to.

26. I subsequently attended all strategy meetings convened by the designated officer on 29 March 2013, 05 July 2013, 28 August 2013 and 08 April 2014.

27. The minutes of the meeting of 29 March 2013 which appear at page 63 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry make reference to a comment made by me "*that we are now five – six months into this investigation and there is no evidence of institutional abuse.*" Throughout my involvement in the investigative process and related actions and as outlined earlier in this statement, I fully shared the concern of all senior staff regarding the circumstances and details of the referral on 08 November 2012 and equally, the circumstances and implications of such a referral being made by staff from a partner organisation. This remained a valid issue and consideration throughout all discussions. I was therefore, in formal investigation meetings and in all informal discussions,

diligent in ensuring that any comments or queries I made related specifically to corroborative and/or substantiating evidence arising or emerging from the investigation. Similarly in these minutes, my reference to Esther Rafferty and Moira Mannion's view related specifically to the outcome of the extensive monitoring and quality assurance arrangements that they had overseen.

28. Copies of the draft final report of the adult safeguarding investigation were tabled at the meeting convened on 05 July 2013, which noted having reviewed the care and protection plan, that "*this is the conclusion of the investigation*," which appears at page 70 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, subject to finalising recommendations Further meetings were subsequently convened on 28 October 2013 and 08 April 2014. Agendas for both further meetings included the review of conclusions and recommendations. The final report entitled the Ennis Investigation Report, commonly referred to as the Ennis Report was dated 23 October 2013.

29. In relation to the adult safeguarding investigation, I worked with a range of stakeholders both external and internal to the Belfast Trust. Externally, this is primarily reflected by membership of the review group which included PSNI and RQIA representation. It also included representation from the two external health and social care Trusts with patients placed at Ennis Ward at that time.

30. During the course of the investigation, in a letter to the health and social care board dated 20 February 2013, I highlighted pressures within MAH additionally demonstrated by this investigation and in particular resources available to assist with the role of designated officers in adult safeguarding. I attach a copy of this letter dated 20 February 2013 at Exhibit 2 attached to this statement. Other representations made just prior to the investigation and precipitated by acute emerging pressures within resettlement wards successfully achieved the temporary funding for an additional six band 6 nursing posts to be deployed to these wards and an enhanced consultant psychiatrist post (80% whole time equivalent). I attach a copy of an email exchange involving Esther Rafferty, Catherine McNicholl and me, dated between 28 November 2012 and 06 December 2012, as well as the funding proposal submitted which secured the

funding at Exhibit 3 attached to this statement. The Belfast Trust had also during 2012 redeployed occupational therapy cover to MAH to support resettlement assessments in the absence of any provision of occupational therapy within the MAH staffing establishment.

31. Within the Belfast Trust, I worked with a range of other staff within the adult social and primary care directorate. This reflected line management and accountability arrangements whereby I reported regularly to Catherine McNicholl to whom I was responsible regarding the response to the investigation and in particular any significant developments/issues emerging through the process.

32. I also worked closely with Esther Rafferty who reported directly to me and to other members of the core senior management group for MAH, namely the Clinical Director Colin Milliken and Mairead Mitchell, who reported directly to the Director, Catherine McNicholl. This forum met fortnightly with a role for governance oversight and both formally and informally reviewed issues pertaining to the investigation and the implication for MAH.

33. I initially also worked with the Senior Service Manager for Community Care and Treatment Services, Barney McNeaney, who had a social work background and reported directly to me and who during the early months of the investigation was the line manager of Aine Morrison the designated officer leading the investigation.

34. On Mr McNeaney's departure in and around March/April 2013, Aine Morrison successfully applied for this post and took up her new role around June 2013, reporting directly to me.

35. In relation to this investigation, there were also strong co-working arrangements with the professional nursing directorate as described earlier in this statement. I therefore worked closely with Moira Mannion who coordinated the Belfast Trust's monitoring arrangements in response to the investigation.

36. Another key interface within the Belfast Trust with whom I worked was the human resources department. This is demonstrated by their representation at

a number of the early strategy meetings and their advice both to senior management and the investigation team throughout this process. This department also had a key role in providing advice to senior management and those commissioning and conducting the subsequent disciplinary investigations.

Q5. How, in your perception, was the Ennis report received by senior management and how did they respond?

37. From the outset, senior management took the concerns extremely seriously as demonstrated by the prompt and comprehensive action taken which included extensive monitoring and surveillance of practice and a specific service improvement aspect led by Moira Mannion.

38. These measures took full cognisance of the source of the concern being staff from a partner agency. Arrangements were also in place throughout what proved to be a lengthy investigation, for monitoring of its progress up to director level of senior management.

39. Therefore, on receipt of the final report, there were no unanticipated issues and it was noted that substantial action had been taken to address staffing deficits, environmental concerns within the ward and other measures to improve the management of patients and their experience on Ennis Ward. Consideration was given to all aspects of the report's conclusions and recommendations which were accepted and to the evidence and issues which emerged during the investigation process.

40. It was acknowledged that this was an extremely lengthy, intensive and detailed process during which the investigative team had decided to explore broader issues beyond the initial reported safeguarding concerns. Such an approach, whilst having some negative impacts had however also provided some additional important information including the positive outcome of Aine Morrison's joint review with H92 of vulnerable adult referrals and responses within Ennis Ward over an eighteen month period. Staff's feedback

to the investigating team's interviews with them was also referenced and the final report "*noted the apparently genuine and caring attitude shown by staff in their interviews,*" which appears at page 287 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry.

41. The investigation team also noted that it had been provided with assurances from Bohill staff that they had no concerns about practice on the other wards at MAH where they had also worked.

42. Senior management also acted promptly and actively followed up the recommendation in relation to implementing disciplinary procedures in respect of two named staff. These disciplinary investigations were commissioned by Esther Rafferty. On receipt of these two disciplinary investigation reports and their recommendations, I took the extraordinary measure of initially rejecting both reports as I was aware of the PSNI and Public Prosecution Service's decision to prosecute taking account of their threshold of "beyond reasonable doubt" against the threshold of "balance of probability" in the Belfast Trust disciplinary processes. I therefore spoke to the disciplinary investigation team and instructed that they should have a full discussion with Aine Morrison regarding the content and conclusions of their investigation report before resubmitting to me. The final report which was resubmitted following this intervention is included in pages 293 to 376 in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry.

Q6. How, in your perception, was the Ennis report received by ward staff and how did they respond?

43. When Esther Rafferty came into post in January 2012, she immediately identified staffing pressures not previously highlighted. There was also anxiety amongst staff regarding the future implications for job security alongside the resettlement agenda. Whilst such concerns were addressed through staff meetings, it was promptly agreed to establish a Workforce Strategy Steering

Group, which was convened during February 2012. This forum, which I chaired, included membership from all relevant trade unions, other Trusts, senior MAH staff, together with representation from Belfast Trust's human resources and finance staff. Through this forum, arrangements were made for regular joint briefings for staff conducted jointly by Esther Rafferty and a designated member of human resources' staff. Provision was also made for meetings with individual staff members with a particular focus and priority given to those working in resettlement wards.

44. Specific assurances were provided about potential redeployment options across services within the Belfast Trust but particularly within Learning Disability which had plans in place to significantly develop its community care provision both to assist with resettlement but also prevent future inappropriate hospital admissions. Working in partnership with other Trusts also facilitated awareness of other planned initiatives both in the statutory and voluntary sectors which may be of interest to staff. Staff feedback regarding this development was positive. The Terms of Reference and Minutes of an early Workforce Strategy Steering Group meeting held in June 2012 are attached as Exhibit 4 and Exhibit 5 respectively to this statement. Alongside this and in recognition of the staffing pressures at MAH, extraordinary arrangements were made for rolling recruitment processes to be expedited for vacancies at MAH.

45. It is fully acknowledged by senior managment up to director level that the events around the Ennis investigation proved extremely difficult for all staff at Ennis Ward and that it also coincided with a period of acute staffing pressures. This is clearly referenced in numerous documentation to which I had access including the monitoring and service improvement reports provided by Moira Mannion, numerous RQIA reports and the reports and minutes of the safeguarding investigation. It was also the subject of discussion and consideration at the MAH core management group meetings convened every fortnight. It is significant to note that many of the issues concerning staff coincided with the disruption caused to patients by the intensive monitoring arrangements and the impact of many new faces on Ennis Ward. All reports highlight a consequent deterioration in the behaviour of patients.

46. Staff also reported on the personal and professional impact of the monitoring arrangement and the potential anxiety and fear this instilled about the possibility that their behaviour or interventions could be misinterpreted. There was also expressed concern about not being fully aware of the full details of the reported concerns and action taken and planned. The time taken to complete the investigation was a further factor in creating prolonged uncertainty and anxiety for staff.

47. This was regularly reviewed through the adult safeguarding processes involving both PSNI and RQIA and staff were provided with updates by Esther Rafferty and Aine Morrison.

48. Arrangements were also made for joint feedback to be provided to staff on the conclusion of the investigation and at a meeting on 08 April 2014 Esther Rafferty and Aine Morrison confirmed that this had occurred.

49. Inevitably, in such circumstances it was widely acknowledged that this was an extremely difficult and disruptive time for all staff on Ennis Ward. This also coincided with changes in leadership at ward manager level and a significant level of scrutiny of practice and patient documentation both internally and externally.

50. Despite these circumstances, staff showed significant resilience and resolve to maintain good patient care and this is additionally evidenced by the notes of the comprehensive staff interviews contained in the adult safeguarding investigation report itself and the disciplinary investigation reports. The positive comment of Aine Morrison in the final report is already referenced above.

51. It is also significant that given the protracted nature of the adult safeguarding investigation, there had already been very substantial changes to the composition of the ward team at its conclusion and work had substantially advanced in the resettlement plans for a significant number of patients on Ennis Ward.

Q7. What was your role in the implementation of the recommendations made by the Ennis Report? It is anticipated that the answer to this question will include, but not be limited to:

- **A detailed explanation of your specific role(s) and actions taken;**
- **An explanation of who you reported to in respect of any actions;**
- **If you worked with others, an explanation of who they were and the role(s) they carried out.**

52. As noted above, the final report was dated 23 October 2013. It outlined fourteen conclusions and made nine recommendations. The implementation of these recommendations was led by Esther Rafferty who reported back at the further strategy meeting held on 08 April 2014. The nine recommendations were as follows;

- **Disciplinary investigations in relation to H197 and H159 H159**. Terms of reference were set by Esther Rafferty who commissioned Rhonda Scott, Senior Nurse Manager and Geraldine Hamilton, Senior Service Improvement manager for Mental Health to conduct the investigation which commenced around September 2013 having initially been delayed awaiting PSNI agreement to proceed.

- **The Ward Environment**. Whilst acknowledging that numerous environmental improvements had been promptly made as noted in the minutes of previous strategy meetings and Moira Mannion's briefing reports, Esther Rafferty confirmed at the meeting on 08 April 2014 that senior staff at the hospital continue to undertake visits to wards for which they are not responsible and report back on environmental issues. This included visits by the senior operation managers and that whilst aware of the constraints of imminent ward closures, minimum standards in relation to privacy and dignity were being monitored and maintained in all wards. It was also noted that this remained a core component of ongoing RQIA inspections.

- **Staffing**. Whilst the safeguarding investigation noted the positive impact of the application of the Telford formula, Esther Rafferty confirmed on 08 April 2014 that a full review had been conducted in relation to two incidents reported on 18 September 2012 and 23 October 2012 relating to staff shortages and a more robust system had been developed to promptly highlight any staffing concerns to senior management and RQIA.

- **Induction Arrangements**. As reported at the meeting on 28 October 2013, it was confirmed that the processes to induct visiting staff had been reviewed and updated in order to address this recommendation. It was also noted that the revised induction arrangements also included a process for evaluation.

- **Patient** [redacted]. It was confirmed that this patient's needs had been reviewed specifically in relation to her support needs and managing her time in the garden. Guidance had also been provided and implemented by staff.

- **Patient** [redacted]. Esther Rafferty reported that prior to her discharge to a community placement, any practices which could be regarded as restrictive had been fully reviewed and documented accordingly. Care plans had been updated with issues of restrictive practice and deprivation of liberty recorded in these plans.

- **Sharing of Information**. Esther Rafferty and Aine Morrison confirmed that the sharing of information with staff had been jointly actioned, but it was acknowledged that some aspects had been constrained by human resources and PSNI advice.

- **Deprivation of Liberty Training**. Esther Rafferty confirmed that all staff had completed this training.

- **Adult Safeguarding Training**. It was further noted that this had now been completed for all staff and behaviour support plans were being actioned for six patients.

53. As highlighted above, the recommendations from the Ennis Report were reviewed through the project management arrangements within the adult safeguarding process and I worked through senior staff at MAH and this oversight group to review implementation.

54. In relation to all aspects of my role as Co-Director, I reported to and was responsible to Catherine McNicholl. Recommendations arising from inspections and investigations were also subject to discussions and review at MAH core management review meetings.

Q8. Did you encounter any challenges or difficulties in your role in the Ennis Investigation or the response to it? If so, please explain what they were?

55. A significant challenge was presented by the safeguarding investigation in terms of the length of time from its inception to its conclusion. This had a negative impact particularly for staff at Ennis Ward and as outlined earlier in my statement, was disruptive to patients. If the concerns identified and presented early in the investigation had been disaggregated and a more focused approach agreed and adopted for the safeguarding investigation, much of this delay may have been avoided.

56. A related issue was the application of the terms of reference of the subsequent disciplinary investigations in relation to H159 and H197 which contributed to further delay in bringing these matters to a conclusion. I consider that the focus should have concentrated on point one of these terms of reference, as outlined on page 296 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry. This, I believe, would have prevented unnecessary delay and duplication of comment on the broader context being addressed by the Belfast

Trust, RQIA and through the safeguarding investigation. Significantly and importantly, this would have prevented the additional requirement for all staff at Ennis to be re-interviewed by a second investigation team.

57. An additional issue related to the Ennis investigation is highlighted in the records included at Section 11, pages 577 to 581 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry which is titled "Timeline of Ennis Investigation (January 2010 to April 2016)." This relates to discussions surrounding a draft letter prepared by Aine Morrison to relatives of patients at Ennis Ward. Shortly after my return from annual leave on 28 November 2012, I was contacted by Esther Rafferty, who expressed concern regarding the content of this draft letter to the relatives of all residents in Ennis Ward. Esther Rafferty immediately assured me that all relatives had been promptly and fully appraised of the concerns raised on 08 November 2012, and arrangements were in place to provide updates, both routinely and promptly in the event of any significant developments. Esther Rafferty questioned the necessity to provide a formal letter unless this was specifically requested by relatives as it was likely to cause additional anxiety and attract potential public interest, when at this stage of the investigation no further information was available. She was also particularly concerned regarding the impact of this letter on those staff continuing to work at Ennis Ward. I understood and shared Esther Rafferty's concern and undertook to take steps to delay the issue of this letter pending further discussion on Aine Morrison's return from leave. I also agreed that the most effective means of communication was through personal contact, whereby questions and queries can be immediately addressed and clarification provided. The content of a revised letter was subsequently agreed, in discussion with Aine Morrison, Barney McNeaney and John Growcott, on 04 January 2013. In reviewing the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, I note the first recorded commitment to provide a written update to families following telephone contact was at the strategy meeting held on 12 December 2012, which is referred to at page 35 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry. At a subsequent strategy meeting

on 09 January 2013, it is noted that the format for a letter to relatives had been agreed and will be sent "*once telephone contact has been completed,*" which is referred to at page 54 Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry.

Q9. Having received and considered the bundle of documents provided by the Inquiry relating to Ennis, do you wish to provide further detail or comment on any issue(s) arising in the documents?

58. I wish to comment specifically on the serious allegations about my conduct during the Ennis investigation by Aine Morrison. I was not aware of these allegations until receipt of this information from the Inquiry and refute specific comments attributed to me. This is referenced on pages 582 to 586 Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry and is entitled "record of teleconference Thursday 16 January 2020".

59. I am acutely aware that in both the conducting of adult safeguarding investigations and disciplinary proceedings, the threshold to be considered is "*the balance of probability*" and I believe that in all of my discussions throughout the investigation, I reflected this.

60. As outlined repeatedly, a referral from a partner agency must be treated extremely seriously and I was confident that this was reflected in my approach throughout the investigation and indeed by all senior management up to director level in both the adult social primary care and nursing directorates.

61. In all discussions that I had with Aine Morrison, I did not question the weight that should be afforded to a referral of this nature from this source and in all of my discussions and engagement, I am confident that any and all of my references to the concept of evidence drew a clear distinction between that afforded to the reported concerns from a number of sources and that which emerged during the investigation of a substantive or corroborative nature. In

relation to the issue of using staff photographs to aid identification, I was not "*extremely opposed*" to this, which is referenced at page 584 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, but regarded it as a legitimate and reasonable consideration to be reviewed during the investigation. Advice was sought on this issue from human resources and this is reflected earlier in this statement. Rather than being dismissive of the suggestion, I convened a meeting with Aine Morrison and her then line manager, Barney McNeaney to further consider this issue and the outcome is confirmed in the minutes of the investigation meeting held on 23 March 2013, when it was noted that it was agreed that this action would not be pursued at that stage.

62. I can categorically state that at no time and on no occasion did I dismiss the reported concern on the basis that "*the Bohill staff hadn't been on the ward that long*." I can also state that any discussions with Aine Morrison regarding the concept of "*proof*" were clearly referenced within the context of "*beyond reasonable doubt".*

63. I note Aine Morrison's contention in the final paragraph of page 584 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry that "*disciplinary action was not taken*". This is completely untrue as evidenced by the disciplinary investigation reports contained in the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry. On receipt of these disciplinary investigation reports at the time they were submitted to me, I promptly returned them to the authors and requested that they fully discuss their investigation and its outcome with Aine Morrison before resubmitting. I took this decision unilaterally on account of my own concern as noted earlier in this statement that the PSNI and the Public Prosecution Service were pursing the two named individuals for criminal prosecution which had an evidence threshold of "*beyond reasonable doubt*" whereas the Belfast Trust's threshold was "*on the balance of probabilities*". It is not true that this decision on my part was the result of any discussion or representations made to me by Aine

Morrison who would not have had access to these reports or details of the outcome at that stage.

64. Other comments in the document included at pages 582 to 586 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry are also of concern to me including reference to Aine Morrison advising me that these two staff were "*dangerous*". This, I assume, relates to H159 and H197. I have also reviewed the minutes of all strategy discussions and can find no reference in any protection plan that individual named staff "*should not be near vulnerable adults*" as Aine Morrison suggests. I also note that the conclusions and recommendations section of the safeguarding investigation report which appear at page 286 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, states and is confined to *"MAH should pursue a disciplinary investigation in relation to the conduct of* H197 H197 *and* H159 *"* Similarly, I note Aine Morrison's reference to feeling that "*social work was pretty unwelcome on the hospital site*," which appears at page 585 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry. This is my first report of this and was not my experience or that of other senior management in relation to H92 's participation as a senior member of the hospital staff and his team's feedback on their experiences. I also note the reference to John Growcott raising "*concerns about independence of internal investigation,*" which also appears at page 585 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, which I assume relate to the disciplinary investigation. I cannot recall any matter of this nature being raised contemporaneously.

65. I was reassured from an early stage in this investigation that arrangements were in place to ensure a direct line of accountability to the executive director of social work as procedurally required. This is referenced earlier in this statement. I am confident that any contemporaneous concern regarding my conduct or approach (or that of any other Belfast Trust officer) to the integrity of a safeguarding investigation would have been immediately escalated and

there would have been an expectation of the designated officer to do so. I do not understand why these issues have been raised apparently on the first occasion some seven to eight years later.

66. A further issue highlighted at pages 577 to 581, Section 11 of the Module 6b: Ennis Ward Adult Safeguarding Report (August 2013) Bundle for Witnesses provided to me by the Inquiry, which is titled "*Timeline of Ennis Investigation (January 2010 to April 2016)*," relates to the completion of a Serious Adverse Incident report in response to events at Ennis Ward. On receipt of the initial reported concerns on 08 November 2012, I understand that the Belfast Trust decided to respond by immediately initiating a Vulnerable Adults Investigation and not to immediately categorise or report this as a Serious Adverse Incident. This would however remain the subject of continuous review. In my absence, I assume that this decision was taken at Co-Director or Director level in consultation with Mairead Mitchell. Mairead Mitchell kept me fully appraised about subsequent correspondence from the Health and Social Care Board to request completion of a Serious Adverse Incident notification. This was the subject of numerous discussions with Mairead Mitchell, which contemporaneously took account of the progress and eventual outcomes of both the vulnerable adult and disciplinary investigation reports, and the significant assurance to senior management, in respect of both the process being followed and the safety of patients, provided by the extensive monitoring arrangements and reports coordinated and provided by Moira Mannion. Mairead Mitchell's role was an advisory one to senior management and in retrospect, I acknowledge that by not complying with the Health and Social Care Board's request at an early stage was a mistake and that there were potential additional benefits to the level of scrutiny which would have been facilitated through the Serious Adverse Incident procedure. I accept my responsibility in relation to this.

Q10. Please provide details of any matters in respect of Ennis not covered by the above or your experience of Muckamore Abbey Hospital generally that you feel will assist the Panel in addressing the Terms of Reference.

67. In response to uncertainty regarding the configuration of MAH on the completion of resettlement, the Belfast Trust established a Hospital Modernisation Group during 2014. The remit of this group was to review the existing commissioning plan for an eighty-seven bed hospital on the discharge of all remaining delayed discharge patients for whom the hospital was having to provide accommodation in the absence of discharge to alternative and more appropriate social care placements. The membership of this group included senior managerial and clinical staff and also representation from the Health and Social Care Board, the Public Health Agency, and other referring Trusts.

68. During its deliberations, this group coordinated an extensive analysis of admissions from 01 April 2009 to November 2015. On the basis of this analysis a phased draft plan was prepared during November 2015 outlining a vision of a future hospital of forty-seven (not eighty-seven) beds. I attach a copy of this draft plan at Exhibit 6 to this statement. This draft plan also highlighted the gross deficiencies in skill mix at the hospital and sought to address this in its proposals. This additionally reflected the Belfast Trust's frustration regarding the non-recurrent basis on which skill mix had been temporarily supplemented during the resettlement phase through strong representations to the commissioner. This issue was also a recurring theme of RQIA inspections. The nature and extent of this issue is reflected in the minutes of this group's meetings held on 09 January 2015, 06 March 2015 and 19 June 2015, which I have attached as Exhibit 7, Exhibit 8 and Exhibit 9 respectively, to this statement. The work of this group also reflected the continuing and incessant pressure on beds at MAH through continuing new admissions and the lack of adequate community treatment and care services within all referring Trusts. I attach an email dated 07 August 2015 which I sent to Aidan Murray of the Health and Social Care Board and Molly Kane of the Public Health Agency alerting them again to acute bed pressures and that MAH was again at full capacity and could not safely contemplate any new admissions.

Giving Evidence

69. I am happy to give oral evidence to the Inquiry if that would be of assistance.

70. If I am asked to give evidence, I do not require any special arrangements.

71. I do not require a supporter to attend the Inquiry hearing with me.

72. I am happy to give my name.

Section 5: Declaration of Truth

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are relevant to the Inquiry's terms of reference.

Signed: John Dean

Date: 23rd February 2024.

List of Exhibits of John Veitch

Exhibit 1 – Email exchange between Yvonne McKnight and Cynthia Crutchley dated 24 January 2013 to 31 January 2013.

Exhibit 2 – Letter dated 20 February 2013 from John Veitch to Aidan Murray of Health and Social Care Board.

Exhibit 3 – Email exchange between Esther Rafferty, John Veitch and Catherine McNicholl dated between 28 November 2012 and 06 December 2012 and funding proposal document.

Exhibit 4 – Workforce Strategy Terms of Reference.

Exhibit 5 – Minutes of Meeting dated 20 June 2012 of Workforce Planning Steering Group.

Exhibit 6 – MAH Modernisation Group Proposal for Muckamore Abbey Hospital.

Exhibit 7 – Minutes of MAH Modernisation Group meeting on 09 January 2015.

Exhibit 8 – Minutes of MAH Modernisation Group meeting on 06 March 2015.

Exhibit 9 – Minutes of MAH Modernisation Group meeting on 19 June 2015.

Exhibit 10 – Email dated 07 August 2015 from John Veitch to Aidan Murray of Health and Social Care Board and Molly Kane of Public Health Agency.

Exhibit 1

Templer, Sara

From: Crutchley, Cynthia <cynthia.crutchley@belfasttrust.hscni.net>
Sent: 31 January 2013 17:06
To: Hegarty, Deirdre
Cc: Veitch, John
Subject: RE: Request for legal advice

Yvonne – I have spoken with June Turkington DLS regarding this and that albeit you may be breaching confidentially of the employee because of these circumstances which potentially may lead to a criminal investigation etc and her advice is

1. in Terms of Vulnerable adults investigation – when management are required to provide information on staff members to the VA they should be providing information that is current on the member of staff. Where there has been previous disciplinary issues this information should be also shared with the VA but it should clearly indicate that this was x years months ago and is now no longer a live sanction.

2. in terms of information requested by the POLICE in these circumstances. This information must be requested by the Police on the relevant form (I think it' s a form 80) this is normally addressed either to the relevant manager or the HR dept. As this is a police investigation we are required to provide all information requested, however again if there are old disciplinary issues these do need to be shared with the clear indication that they are no longer a live sanction.

I trust this helps to clarify the issues raised happy to discuss.

Cynthia

From: Hegarty, Deirdre
Sent: 31 January 2013 13:17
To: Crutchley, Cynthia
Subject: FW: Request for legal advice
Importance: High

Cynthia

Can you please advise re the outcome of your consultation with Legal Services.

Regards, Yvonne

From: Hegarty, Deirdre
Sent: 24 January 2013 12:36
To: Crutchley, Cynthia
Cc: Morrison, Aine; Hegarty, Deirdre; Kernaghan, AnnC
Subject: Request for legal advice
Importance: High

Cynthia,

At the last Muckamore case conference, a further discussion took place in relation to the Adult Safeguarding investigation' s previous request for information

Exhibit 2

Belfast Health and Social Care Trust

20th February 2013

Mr A Murray
Assistant Director of Social Services
Health & Social Care Board
12-22 Linenhall Street
BELFAST

Dear Mr Murray

Re: Vulnerable Adults Resource

You will be aware of on-going issues of concern relating to Vulnerable Adults incidents in Muckamore Abbey Hospital. Most recently there have been a number of concerns raised with the Trust concerning Vulnerable Adults issues on a specific ward related to allegations (as yet un-adjudicated) into abuse and rough handling of patients by a small number of staff on Ennis Ward. As you know from our recent discussions the Trust has in place a robust and comprehensive response. We are also aware of similar issues in relation to a Western Trust facility.

As part of our enhanced monitoring processes in Muckamore Abbey Hospital and the wider protection plan directly related to the Vulnerable Adults allegations in Ennis we have had to review our Vulnerable Adult processes within the hospital and significantly enhance them to deal with what has been an exponential rise in Vulnerable Adult incidents. I am also aware that the rise in such incidents is under close scrutiny across the region, by your colleagues in the Board and that the evaluated position is that the rise is due to more robust procedures coupled with a rise in frequency and acuity of Vulnerable Adults reports. This is no surprise given the heightened monitoring of this area of our work following national incidents such as Winterbourne View and the greater, growing complexity of our service users in Muckamore Abbey Hospital.

As part of our protection plan we were able to secure additional resources from our colleagues in Mental Health to assist with the role of designated officers. These are of necessity of a temporary nature until we have had the chance to review the wider resources available to meet need. This arrangement is rapidly coming to an end and decisions will be required as to the future resource required to meet this significantly enhanced need.

Belfast Health & Social Care Trust, Social Services Family & Child Care, Fairview 1, Mater Hospital Site, Crumlin Road, Belfast BT14 6AB Tel 028 95046918 Fax 028 90802101 Email: john.veitch@belfasttrust.hscni.net

I am aware also that the HSC Board has recently agreed to fund additional posts to more effectively manage Vulnerable Adults processes across all Adult Services. Whilst we are hopeful that the Learning Disability Programme will be allocated a fair share of these additional resources our recent review has clarified that a minimum of two additional Band 7 posts will be required, initially for deployment in Muckamore Abbey Hospital, to deal effectively with the rise in VA reporting and the requirement for greater scrutiny.

Within this context I wish to request that urgent consideration is given to funding one additional Band 7 post specifically for VA work in Adult LD services plus 0.5 wte of a Band 3 Administration worker. We believe that this service has previously been significantly underfunded and the VA process has rested, by default, on the Social Work Department in the hospital, preventing them from providing their much needed wider service to the hospital and our service users. With the continuing rise in VA reporting and the relentless focus on such issues in institutional care we are experiencing significant additional demand.

We would also welcome a meeting with you to establish if progress can be made in the near future to address this pressing issue if you consider that this could help expedite arrangements.

Yours sincerely

J Veitch (Mr)
Co-Director for Learning
& Children's Disability Services

Belfast Health & Social Care Trust, Social Services Family & Child Care, Fairview 1, Mater Hospital Site, Crumlin Road, Belfast BT14 6AB Tel 028 95046918 Fax 028 90802101 Email: john.veitch@belfasttrust.hscni.net

Exhibit 3

Templer, Sara

From: Kerr, Hayley on behalf of McNicholl, Catherine
Sent: 06 December 2012 08:50
To: Veitch, John
Cc: McNeany, Barney; Cameron, Margaret; Rafferty, Esther; OKane, Maurice
Subject: FW: Additional Resources Paper
Attachments: community integration project - paper for additional resources - 03.12.12.doc; resettlements.xls

Thanks John and all

Happy for you to go ahead and submit to the Board.

Many thanks,

Catherine

Mrs Hayley Kerr
on behalf of Catherine McNicholl
Director of Adult Social & Primary Care
Belfast Health & Social Care Trust
Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast, BT9 7AB
Tel: 028 950 40125

From: Harris, Lesley **On Behalf Of** Veitch, John
Sent: 03 December 2012 12:21
To: McNicholl, Catherine
Cc: McNeany, Barney; Cameron, Margaret; Rafferty, Esther; Okane, Maurice; Kerr, Hayley
Subject: FW: Additional Resources Paper

Catherine

Please find attached proposal and costing proforma in relation to additional staffing resources associated with the Community Integration Project. As you should be aware this bid has been invited by the Board. If content I should be grateful if this could be URGENTLY forwarded to Fionnuala with copies to Aidan Murray, Adrian Walsh and Seamus Logan.

John

From: Rafferty, Esther
Sent: 28 November 2012 10:17
To: Veitch, John; Harris, Lesley; Okane, Maurice
Cc: McNeany, Barney; Cameron, Margaret
Subject: Additional Resources Paper

John

I had discussed this paper with Catherine McNicholl and she had asked me to get the finance template completed and verified with M Blaney and also to include administrative support also required to the project.
Michael and Paidi have confirmed they are now happy with this

Esther Rafferty
Associate Director of Learning and Children Disability Nursing
Service Manager
Muckamore Abbey Hospital
1 Abbey Road
Antrim

Mobile RO1
02894 463333

Community Integration Project – Paper for Additional Resources

Background

The Belfast HSC Trust remains fully committed to the completion of resettlement for patients with a Learning Disability who no longer require active Hospital treatment. Resettling the remaining patients at Muckamore Abbey Hospital requires careful person centred planning, the demonstration of betterment for each patient and full engagement with the Multi-disciplinary team in order that the Trust can fully meet Ministerial targets.

Our experience demonstrates that, as the resettlement process progresses, the individual service users involved in resettlement have increasingly complex needs. Therefore the need for detailed multidisciplinary and multiagency working and for skilled clinical input, to plan and meet a range of challenges, including mental illness, epilepsy, forensic and other complex medical needs is creating ever greater demands on clinical time.

Medical Team Job Plans have recently been reviewed and reorganised and the Trust has identified the urgent need for increased clinical capacity through a temporary expansion of the Consultant workforce in the Psychiatry of Learning Disability in order to more actively make progress on the resettlement project.

Proposal

Additional Consultant psychiatric input, focused solely on resettlement, will allow an effective team structure to develop, delivering safe and effective plans for patients from all community Trusts, building on investment in Nursing, Care Management and Occupational Therapy. Quality will be improved, and a fragmented approach avoided through the development of a dedicated team-based approach. This additional clinical resource will be devoted solely to the completion of resettlement by the end of March 2015.

When resettlement is complete, this clinical resource subject to review could be refocused on reducing, and where possible preventing, Hospital admissions. The HSC Board has made a significant investment in developing a putative intensive support team with the aim of ensuring Service Users remain supported in the community. The initial investment (Year 1 of 3) made by the HSC Board includes funding for 0.2 wte Consultant Psychiatrist. Trust plans recognise that in years 2 and 3 additional support for developing community psychiatry will be required to ensure the aims and objectives of the intensive support team are fully met. The psychiatrist will be involved, with other disciplines and management, in designing and delivering a high quality home treatment/intensive support model for Learning Disability. The literature base and clinical experience describe models which could clearly reduce admission rates and ensure there is no "next generation" population of Service Users who require resettlement.

Additional Investment Benefits.

The recent team job planning process demonstrates that, with this proposed Consultant expansion, existing resources could be redeployed to provide much needed community forensic services across the Trusts, streamlining existing provision to develop a single Consultant input to the South Eastern Trust and dedicated Consultant input to CAMHS LD services, both in Iveagh and in community Trusts.

FUNDING

The Trust seeks to accelerate the proposal to initially establish Consultant Psychiatrist input into the resettlement project and then into an intensive support team. We seek to enhance community infrastructure to fund 0.8 whole time equivalent Consultant Psychiatrist in Learning Disability to underpin the existing investment in the intensive support team and allow the Trust to realise the additional benefits identified above.

Community Integration Project – Nursing Resource Requirements

Ward Staffing

Background

The Belfast HSC Trust is fully committed to the completion of resettlement for patients with a Learning Disability who no longer require active Hospital treatment. Resettling the remaining patients at Muckamore Abbey Hospital requires careful person centred planning, the demonstration of betterment for each patient and full engagement with the Multi-disciplinary team in order that the Trust can fully meet Ministerial targets.

The need for detailed multidisciplinary and multiagency working and for skilled nursing input, to plan and meet a range of challenges, including mental illness, epilepsy, forensic and other complex medical needs is creating ever greater demands on our clinical time.

The resettlement wards are operating at a staffing level and skill mix that is reflective of the ongoing continuing care needs of the patients but is not staffed as a treatment ward. As the resettlement and community integration process requires primary nurses to proactively engage in person centred care planning and risk assessment and management activities to identify community providers or services that will meet the patients needs and show betterment, there is a need for temporary additional resources to facilitate these processes. These are additional day to day work pressures which would not routinely been undertaken as the patients "lived" in these wards.

The nurses' role is key to the successful engagement of carers and families as well as supporting new providers to become confident and competent in meeting the needs of the patients prior to discharge.

We seek to enhance each resettlement ward structure by the temporary addition of a band 6 deputy ward manager. This will provide governance support to the management of the ward and the lead role for the community integration processes and meetings and a conduit for the primary nurses to become meaningfully involved in the resettlement processes. Therefore the Trust is seeking six whole time equivalent Band 6 nurses. This will reduce to 4 wte with the closure of two wards by March 2014.

Community Nursing Staff

In addition to this we acknowledge that learning disability nurses can enhance the success of community placements. The majority of placements developed are in social care settings and models; therefore we need to in- reach nursing skills to support the patient and develop robust management plans for each individual's community nursing needs to ensure integration and resettlement successes for the individual patient. To this end we are seeking to further enhance the community learning disability nursing resource with an additional band 6 nurse.

Administrative Staff

The community integration project requires administrative support to the wards, resettlement meetings, regional meetings and care management. 2.5 wte band 3 clerical posts will provide assistance to follow processes, collate assessments and organise meetings associated with resettlement. This cover will also provide secretarial support to the Consultant post.

FUNDING

Find enclosed table of costs for year end and for the remaining two years of the project.

Exhibit 4

Project Board Community Integration Project – Workforce Strategy

Terms of Reference

- To oversee the arrangements in compliance with Trust Framework (2010) for the management of staff affected by organisational change and with all legislative requirements

- To ensure that staff and their representatives are involved and fully consulted in relation to all aspects of the project

- To ensure that the needs and interests of patients remain central to all considerations and there is a shared commitment to the principle of "betterment" for patients in addressing all staffing/human resource implications

- To monitor progress on the preparation and deployment of staff consistent with continuing implementation of the

    1. Equal Lives Learning Disability Report September 2005
    2. Excellence & Choice Learning Disability February 2010
    3. Regional Project Plan for the "Resettlement of Individuals with Learning Disability Muckamore Abbey" dated 24th August 2011 and issued in final form 29th December 2011

- To identify, highlight and seek to promptly address any resource issues including finance which may emerge

- To ensure that due cognisance and attention is given to the identification and addressing of potential governance issues including any issues relating to staff development and training

Belfast health & Social Care Trust

Muckamore Abbey Hospital

Notes of Workforce Planning Steering Group Meeting

Held on Wednesday 20th June 2012 at 9.30am
In the Boardroom, Admin building, Muckamore.

Present:

Esther Rafferty Service Manager
Barry Mills Clinical & Therapeutic Services manager
Rhonda Scott CIP Co-ordinator
Joan Peden Human Resource Department
Neil McDaid Human Resource Department
Joe McCusker Unison
Margaret Campbell Unison
Joe McCambridge RCN
Davey Downes NIPSA
Damien Maguire NIPSA
Carole Veitch South Eastern Trust
Nancy Scott Senior Manager PCSS

Apologies

John Veitch Co- Director Belfast Trust

Minutes of Meeting

Agreed and to be sent prior to next meeting.

Matters Arising

- Terms of Reference to be circulated with minutes.
- Project Group membership – it was agreed to invite a Northern Trust representative to the meeting. Rhonda Scott to liaise with other departments to ensure appropriate representation.
- Community Integration Update – planning is now underway in the targeted wards for this year 2012 /13 in addition to completing last year's wards. It is anticipated that we are planning to resettle 60 patients each year across each Trust area to achieve overall targets by 2015.

- Staff engagement process – The staff information day appeared to have been well attended and received.

- Retirement Option – This policy has now been updated, staff can avail of flexible retirement of a reduction in their hours pre retirement if requested.

1. Communication

It was agreed that the community integration project would be an agenda item on the monthly managers meeting on site so that information on its ongoing progress can be communicated back to nursing staff.

It was agreed to consider holding a second day in late Autumn (November) for staff from all departments; date to be agreed at next steering group meeting.

2. Current Affected Groups

Following the staff information day it was agreed to offer 1:1 sessions for staff in immediately affected areas to discuss options available to staff. Managers from all areas to convene meetings with their respective affected groups during June / July. Discussion followed on the way forward

- A list of available posts would be available at these sessions,
- Staff can avail of union representation at meetings.
- It was agreed that a three month trial period for all redeployments
- Staff will be offered two reasonable offers as part of the process

At the next meeting further affected areas would be discussed in line with progress under the project. Forms for all staff will be sent out once current affected areas meeting s complete.

Discussion took place regarding support for staff relocating back into the core hospital / other community posts from the resettlement wards and skills set required. Staff to be offered interviewee skills training as required or any appropriate course depending on needs identified.

It was agreed that each department would examine their future staffing needs for March 2015 when the core hospital remains. Rhonda Scott agreed to convene a sub group meeting prior to next Steering group to share information collated by each department.

Any Other Business

Damien Maguire Nipsa raised how this retraction fit in with the Trust Delivery Plan and Adult Care Savings and would this impact on resettlement. It was shared that all patients being resettled had an agreed funding amount to meet their needs on discharge / resettlement and to show betterment. There was also investment in all

Trust areas for community infrastructure. The retraction of the wards was built into the process to fund and manage the resettlement process.

Date and Time of Next meeting

12th September 2012 at 9.30am Boardroom Muckamore Abbey Hospital

 Exhibit S

Belfast health & Social Care Trust

Muckamore Abbey Hospital

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Date and Time of Next meeting

12th September 2012 at 9.30am Boardroom Muckamore Abbey Hospital

Exhibit 6

Belfast Health and Social Care Trust

Adult, Social & Primary Care Directorate, Learning Disability Service Group

MAH Hospital Modernisation Group
Proposal for Muckamore Abbey Hospital

November 2015

Belfast Health and Social Care Trust Learning Disability Service Group

Introduction

The Belfast Health and Social Care Trust (the Trust) provides Specialist Assessment and Treatment Inpatient services at Muckamore Abbey Hospital.

Muckamore Abbey Hospital is commissioned to provide acute care to those individuals with an intellectual disability with behavioural or mental ill health who require acute inpatient care and treatment. The hospital is commissioned to deliver a total of 62 beds for acute assessment and treatment and 6 Psychiatric Intensive care Beds for the Northern, South Eastern and Belfast Health & Social Care Trusts. It also delivers 19 regional forensic low secure beds.

The hospital continues to provide a small number of long stay beds in two resettlement wards pending the completion of the resettlement of the remaining patients on the Priority Target List (PTL) under the Community integration Project (CIS).

This project which has been lead by the HSCB and in line with the ministerial directive that no one should have a hospital address as their home was due to have been completed by March 2015. The remaining 25 patients have their assessments completed and no longer require hospital inpatient care however their community placement is not yet available. It is anticipated that these patients will be resettled by June 2017.

The actual site the hospital is built on is a large estate with extensive walkways and services. Leisure and outdoor facilities are well developed on site for this patient group. The area is conducive to people with an Learning Disability e.g. taking simple walks outside the wards without the need for supervision or having to have significant risk assessments undertaken. The outdoor space is not overlooked. It is expansive and is considered by staff to be an appropriate and safe temporary setting for patients who can display behaviours of concern. Once their treatment is completed and these behaviours become more manageable reintegration back into their local community is achieved.

The location of the hospital is centrally located for the three Trusts it serves for acute admissions and centrally for the region for the low secure facility.

The Disadvantages of the site is that it still resembles a large institution which contains the remains a large number of buildings and wards which are no longer in use on the site. However the overall site is at a stage where a large proportion of these can be cordoned off and a plan developed for their demolition.

The hospital has over the past 4 years undergone a significant retraction in the number of wards and bed numbers on site. The following long stay wards have been closed since October 2013, Finglass, Rathmullan, Ennis, Oldstone, and Greenan. This has been as a result of the Community Integration Project (CIS) whereby all those no longer requiring hospital assessment or treatment care were prioritised for resettlement. Plans are in place to close the two remaining resettlement wards when a specialist nursing home and bespoke supported living scheme are realised by June 2017 to resettle a number of the remaining priority target list (PTL) patients.

During this period a new emerging population of complex delayed discharge individuals who require similar bespoke intensive support models of community integration has been identified within the hospital. This group of patients now number 49 however 26 of these patients are delayed less than one year. This indicates the ongoing need for Trusts, the HSCB and the DSD to continue to plan, develop and deliver on a continuing number of schemes for future need.

It is acknowledged that in order to appropriately meet the complex needs of these individuals a lead in period is required to deliver the bespoke or enhanced level of community placement required to successfully manage this group of patients in a community setting. Therefore the hospital needs to accept that a small recurrent number of individuals will be delayed in their discharge at any one time. However any delay must be reasonable to realise and deliver the service required and not be contraindicated in line with the Judicial Review outcome of JR47. All trusts should aim to keep the lead in period to deliver a discharge package to less than 26 weeks where possible.

The hospital is also reviewing and addressing the ethos of the inpatient service to develop proactively led and well supported multi disciplinary teams with a culture of transparency and with the skills and attitude necessary to deliver helpful, evidence based, individually tailored interventions informed by a highly detailed, multidisciplinary assessment and treatment plans. This will include ensuring adequate multi professional input from the range of disciplines necessary to address the needs of the patients.

All members of the staff teams will receive in addition to their mandatory training, "in house" training on Positive Behaviour Support and Human Rights including positive and proactive care. A positive Behaviour Support Approach will continue to be rolled out with all team members working collaboratively and respectfully together and in a person centred way with our patients in order to understand the reasons why at times they are showing behaviours of concern. The team's focus will continue to shift from use of more reactive strategies towards the use of more positive and proactive strategies. The service will join the restraint reduction network and set key performance indicators to evidence a reduction in restrictive practices and a continued move to more proactive strategies.

More opportunities for reflection will be introduced in addition to our weekly multidisciplinary meetings. These will include a weekly patient's forum, structured debriefing following incidents with an emphasis on learning from incidents or mistakes, team learning boards, team building days, a weekly reflective practice group, weekly review of Positive Behaviour Support Plans, monthly multidisciplinary review of restrictive practices (linking in with trust wide review by senior management team) and monthly operational team meeting.

All patients admitted to the hospital will commence discharge planning at the point of admission with initially a post admission meeting and then a projected date of discharge. Where possible when an admission is pre-planned the discharge plan will be agreed in advance of the admission. Using this approach community Trusts will have up to date information on the patients profile, presentation and accommodation requirements throughout the period of treatment. This will enable timely discharges to occur and not breach the Human Rights of the individual by requiring them to remain in hospital unnecessarily.

Phase 1

Within the current ward configuration there is an imbalance of beds allocated to males and female patients. This results in occasions when an admission bed is not available in a timely manner in and out of hours to facilitate an admission to acute inpatient care.

The first stage of the modernisation is to change the use of Killead ward to female admissions and Cranfield ward to convert to all male ward.

This will increase the availability of female admission beds and equally balance the number of beds to

29 beds for males and

29 beds for females

6 PICU (male and female)

To date a maximum of 36 patients in any one month have been in active treatment and 25 delayed in their discharge less than 365 days. In addition a number of resettlement patients are residing in the core assessment and treatment wards.

With the complexity and increased acuity of recent admissions 4 beds are not in use in Killead ward due to the creation of two 1 person low stimulus areas. These intensive support areas have been required to minimise adult safeguarding incidents with two patients who severely challenge other patients through proactive adaptation of the environment with proactive and reactive strategies to minimise harm.

This development has reduced the overall core hospital bed numbers from 87 to 83.

It is anticipated that this phase should be can be completed within approximately 3 months

Phase 2

It is anticipated with the discharge and resettlement of those patients no longer requiring hospital care that 40 admission beds will meet the needs of those in active treatment initially. With the establishment of the community infrastructures, crisis response and home treatment / intensive support models being developed and delivered it is expected that the number of patients presenting for admission should reduce. This has already been evidenced in the Southern Trust service model.

Initially 40 admission beds and availability of PICU care will ensure the availability of an admission bed as required. This number of beds includes provision for up to 10 patients who are delayed in their discharge for less than 6 months facilitating community teams an opportunity for appropriate timely placements.

There will be 4 admission wards to provide the least restrictive environment for the patient on admission taking into account safety, gender and security requirements based on the individual needs of those requiring acute inpatient care. With a reduction in the number of patients residing in each ward it is envisaged a concurrent reduction in safeguarding incidents are likely, improved outcomes for those with severe autism with increased available space and less physical assaults evident for staff.

Cranfield ward 1 – restricted access ward male	10 beds
Cranfield ward 2 – open ward male	10 beds
Donegore - restricted access ward female	9 beds
Killead - open ward female	11 beds
Psychiatric ICU	6 beds

As those patients who are deemed to be delayed, are discharged, the bed will be stood down until the above numbers are reached.

This represents a further reduction of 18 assessment and treatment beds to to the overall total of 46 as above.

This will reduce Core Hospital bed numbers from 87 beds to 65 beds. (inclusive of 19 Low secure)

Phase 3

Review of Sixmile Low secure Ward

Sixmile is a 19 bedded low secure regional unit - comprising of 14 treatment and 5 assessment beds. There are 4 non-commissioned beds on the treatment ward.

The current patient profiles are

Belfast Trust – 9 patients

South Eastern Trust – 5 patients

Northern Trust – 3 patients

Southern Trust – 1 patient

5 of these are delayed, 8 are in active treatment and 5 are PTL patients.

The purpose of Sixmile is to provide a service for men with a learning disability who come into contact with the criminal justice system due to their offending behaviour, be it challenging and/or aggressive in nature.

Sixmile at all times seeks to provide the most effective care and support within a low secure unit, which is safe for both patients and staff. The overarching philosophy of care in Sixmile is to encourage rehabilitation and re-integration within the community for individuals who have offended or who are at risk of offending. Given the nature of the client group in Sixmile, management of the staff team centres on the regerian theory of unconditional regard. Nowhere more so in the field of nursing are the values of staff challenged regarding the behaviours of the client. The standards set in Sixmile exemplify the values of non-judgementalism and working in partnership with the patient to maintain safety and to facilitate personal growth.

Since opening, links have been formed with community teams throughout the province, Public Protection Units (PPU,PSNI) Probation Services, Department of Justice and Advocacy services; and liaison with PPANI to appropriately risk assess and manage the transition back to community not to mention our continuing relationship with national bodies such as the National Organisation for the treatment of Abusers, the Scottish Forensic Network and the State Hospital, Carstairs.

The HSCB has in the last month allocated monies for community forensic services to be developed. Sixmile low secure service will support the community developments providing tier 4 inpatient service within the regional LD forensic network.

In managing the forensic service there is a severe shortage of appropriate accommodation options for patients to consider when deemed medically fit for discharge, alongside a lack of appropriate occupational and day opportunities. This has the negative impact of increasing the length of stay in hospital whilst options are explored. There continues to be ongoing issues with restrictive practices and deprivation of liberty issues whereby voluntary patients are residing in low secure services awaiting community placement. It is hoped that once community forensic services are embedded the number of patients in treatment and the profile of the service users would change.

However there remains a lack of low secure treatment beds or access to medium secure within N Ireland for male patients or any service for female patients requiring these levels of treatment and care option. A number of these patients have been transferred to hospitals in mainland UK to facilitate treatment options at low secure treatment and medium secure treatment on ECR referral processes as a result.

Low secure treatment option for males can be facilitated in the current service and facility which should allow for some patients to return to N Ireland and prevent further low secure out of area admissions. This would represent financial savings for the HSCB with less ECR's.

Possible reconfiguration of Sixmile ward

11 low secure forensics beds (male)

6 low secure treatment beds (male)

With the projected downturn in the number of admissions for acute care, a regional low secure treatment can be provided for females with Donegore ward. This facility could provide for 6 low secure beds. However given the complexity of these individuals it is likely 4-5 patients would be in treatment at any one time. Again this will negate the need for these patients to be considered for ECR referrals to mainland UK.

Medium Secure Provision

In respect of those requiring medium secure treatment options the numbers requiring this level of care remain too low to be financially viable to deliver this service however discussions may be possible with mental health services to ascertain if the small number could or should be accommodated. Alternatively where this is required access to mainland services may still be needed.

Finally as community infrastructure models of intensive support become embedded it is anticipated that further reduction in acute admission beds will occur to

2 admission wards of 9 beds and

6 bedded Psychiatric ICU.

This will facilitate 6 admission beds and 2 PICU beds per Trust

This will result in overall reduction in bed compliment from 87 to 47 beds in total.

Total 47 beds
Includes 2 x Acute Admissions,
PICU,
Regional Low Secure M & F Treatment and
Regional Male Low Secure Forensics.

Belfast Health and Social Care Trust Learning Disability Service Group

Nursing Workforce Paper **Appendix 1**

The workforce at Muckamore Abbey Hospital was set in the context of a service which had a number of individuals residing in the wards over a large number of years with some dedicated wards for admissions and a forensic population.
The skill mix, staffing ratios reflected this settled population and patient mix however with changing profiles and acuity levels staffing has been subject to continuous review on weekly and at times daily basis to ensure safe and effective care for patients and staff safety.

A workforce strategy has been in place since mid 2012 whereby the workforce has been in a period of retraction reflecting the number of wards earmarked for closure. However during this period a new and emerging patient population has required increased staffing ratios and skill mix for safeguarding issues, risk management and staff safety. The hospital is transforming from an institution into a functioning assessment and treatment model delivering a range of evidence based interventions. It has been continuously inspected via the regulator of RQIA and peer reviews of QNLD to ensure the correct road of travel to deliver a modern service to those requiring acute inpatient care. Part of this transformation is reviewing and updating the staffing compliments, professional inputs and ratios to meet the projected needs of the patient population. This has been completed using the delivering safe care approach and benchmarking against the other two acute inpatient services in the region.

Belfast Health and Social Care Trust Learning Disability Service Group

Current Staffing

	SHSCT 5 beds	Whsct 10 beds	BHSCT CFM Adm 14 beds	BHSCT CFW Adm 15 beds	BHSCT PICU 6
Band 7	1	1	1	1	1
Band 6	1	4	1	1	1
Band 5	9.8	13	13	13	10
Band 3	8.3	17	11	11	10
Behaviour Nurse	1	0	0.5	0	0.5
OT	0	0	0.25 (T)	0.25 (T)	0.25 (T)
Psychology			0.1	0.1	0.1
SLT			0.1	0.1	0.1
			*	*	*
Consultant			0.5	0.5	0.25

	BHSCT Donegore 9 beds	BHSCT Killead 24 beds	BHSCT Sixmile 19 beds		
Band 7	1	1	1		
Band 6	1	1	1		
Band 5	12	14	15		
Band 3	16	24	14.5		
Behaviour Nurse Or Specialist	1		0.5 1		
OT			0.25		
Psychology	0.1	0.1	1.0		
SLT	0.1	0.1	0.1		
Dietetics	*	*	*	*0.4 for Hospital	
Consultant	0.1	0.2	0.5		

Belfast Health and Social Care Trust Learning Disability Service Group

Proposed staffing

	SHSCT 5 beds	Whsct 10 beds	BHSCT CFM Adm 9 beds	BHSCT CFW Adm 9 beds	BHSCT PICU 6
Band 7	1	1	1	1	1
Band 6	1	4	2	2	2
Band 5	9.8	13	15	15	14
Band 3	8.3	15	10	10	8
Behaviour Nurse	1	0	0.5	0.5	0.5
OT	0	0	0.25	0.25	0.50
Psychology			0.2	0.2	0.2
SLT			0.1	0.1	0.1
Dietetics			*	*	*
Consultant			0.5	0.5	0.5
Social work			0.5	0.5	0.5

	BHSCT Donegore Low secure 6 beds	BHSCT Sixmile Low secure 6 beds	BHSCT Sixmile Forensic 11 beds		
Band 7	1	1	1		
Band 6	2	2	2		
Band 5	15	15	15		
Band 3	10	10	14.5		
Behaviour Nurse Or Specialist	0.5 1	0.5 1	0.5 1		
OT	0.5	0.5	1.0		
Psychology	0.5	0.5	1.0		
SLT	0.1	0.1	0.1		
Dietetics	*	*	*	*0.4 for Hospital	
Consultant	0.5	0.5	0.5		
Social work	0.5	0.5	0.5		

Total 47 beds
Includes 2 x Acute Admissions, PICU, Regional Low Secure M & F Treatment and Regional Male Low Secure Forensics.

Appendix 2

Extracts from Delivering Care. Normative staffing levels for Nursing

1.0 INTRODUCTION

1.1 The subject of nursing in hospital wards has been a topic of debate and discussion for a number of years. Ensuring appropriate staffing has been referenced in inquiries and investigations, shown in research evidence and is viewed by patients and their carers as a key element in influencing the quality of care.

1.2 The Independent Inquiry into the failings of the Mid Staffordshire National Health Service (NHS) Foundation Trust[3] highlighted the need for appropriate staffing levels to support safe, effective, person centred care.

Speaking at the publication of his final report, Robert Francis QC said:
"The Inquiry found that a chronic shortage of staff, particularly nursing staff, was largely responsible for the substandard care."
"The evidence shows that the Board's focus on financial savings was a factor leading it to reconfigure its wards in an essentially experimental and untested scheme, whilst continuing to ignore the concerns of staff."
"People must always come before numbers. Individual patients and their treatment are what really matters.....This is what must be remembered by all those who design and implement policy for the NHS."

2.0 BACKGROUND AND CONTEXT

2.1 There are a number of drivers which have informed the development of the *Delivering Care* Framework. They include:

Regional Policy and Strategy

2.2 A number of key strategic documents underpinned the development of this Framework
including:
Transforming Your Care
The strategic review of Health and Social Care (HSC): *Transforming Your Care*[4] sets out the direction of travel for HSC services in Northern Ireland over the next five years.
This is supported by the Commissioning Plan[5], which details year on year service provision, priorities and standards that services must meet. The implications of the changes to services in the next five years are significant, particularly in the development of new service models and the response the workforce will be required to make in support of these changes. Examples include:
› A reduction in length of stay for patients in hospital environments resulting in a higher concentration of acutely ill older patients with complex co-existing long term conditions, who require more care and treatment and therefore more intensive nursing care
› Changing Hospital services, more care being provided in patients/clients own homes, community and domiciliary settings
› Technology increasingl› Greater emphasis on the prevention of ill health.

Quality 2020
HSC service provision in Northern Ireland is underpinned by the three key components of: safety, effectiveness and patient /client focus as defined through *Quality 2020*[6]. *Quality 2020* refers to 'Strengthening the Workforce', as one of its strategic goals, elements of which include the continuous need to develop the knowledge and skills of the HSC workforce, measured through improved outcomes for patients and clients.

The People's Priorities
Nurses and midwives are the largest staff group in the HSC system providing general and specialist care and treatment in all HSC environments. Nurses and midwives are central to the provision of quality care and are highly valued by the public in Northern Ireland, a view expressed in the Patient Client Council report: *The People's Priorities*[7] which identified the protection of front-line staff, particularly nurses, as the top priority for the HSC organisations. used in support of care delivery

A Partnership for Care
The need to develop a framework to support effective workforce planning was identified in *A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015*[8] and as part of the Health and Social Care Board (HSCB)/Public Health Agency (PHA) Commissioning plan 2011/12[9].

Evidence Base Related to Staffing Levels and Patient Outcomes
2.3 Significant research has been undertaken into the issues of both nurse staffing levels and skill mix, thereby providing a wide literature base in relation to the association between lower numbers of registered nurses and significant reduction of the quality of patient outcomes[10]. Examples include:
› Fewer registered nurses, increased workload, and unstable nursing unit environments were linked to negative patient outcomes including falls and medication errors on medical/surgical units in a mixed method study combining longitudinal data (5 years) and primary data collection[11].
› Features of the hospital work environment, such as better staffing ratios of patients to nurses, nurse involvement in decision making, and positive doctor-nurse relations, are associated with improved patient outcomes, including mortality and patient satisfaction[12]

› Links have been demonstrated between lower numbers of registered nurses and increased length of stay and associated cost.[13]
› The Health Care Commission following an investigation into links between nursing workforce and patient outcomes concluded that staffing levels appeared to be based on traditional and/or costs constraints rather that patient need or outcomes.

ASSUMPTIONS OF THE FRAMEWORK

3.9 It should be recognised that the Framework refers to staffing ranges expressed as nursing/bed ratios. This reflects the view that the family of nursing (or midwifery) comprises both registered and unregistered staff, included collectively within the ratios.

3.10 For the purpose of developing the Framework, a number of underpinning assumptions must be considered when understanding how a range is set and might be used, in conjunction with the factors that influence workforce planning. These assumptions are: *Planned and Unplanned Absence Allowance*

i. The ranges incorporate a Planned and Unplanned Absence Allowance of 24%. This allowance refers to periods of anticipated absence from work and should, therefore, be factored into the workforce planning process. This includes annual leave, sickness[21], and mandatory study leave. This element is further defined at page 14 of this Framework and it should be noted that the defined percentage will be subject to review and potential amendment by the Chief Nursing Officer on the advisement of relevant professional forums, reflecting developments in training requirements and training delivery methods.

Skill Mix

ii. This term refers to the ratio of registered to unregistered nursing/midwifery staff working within a complement of staff in an individual care setting. The level of skill mix required for any particular clinical setting may vary. For example, in critical care settings a skill mix comprising mostly registered staff is required to facilitate safe and effective person centred care; this is due to the complexity and acuity of the patient profile of people cared for in such environments. Conversely, where there are high levels of dependency but a lower level of acuity[22], a skill mix comprising a higher level of unregistered staff may be appropriate.

Skill mix should also take account of an allocation of a Ward Sister's/Charge Nurse's time for managerial and professional responsibilities ranging from 40 – 60% of total available time[23].

A level of skill mix will be determined regionally for a variety of care settings in Northern Ireland by the Steering Group of the Delivering Care Project, in consultation with the Department of Health, Social Services and Public Safety (DHSSPS), PHA, HSC Trusts and staff side organisations. The skill mix relevant to a particular setting will be included within the subsequent '*Using the Framework for..*' sections.

4.0 PLANNED AND UNPLANNED ABSENCE ALLOWANCE

Definition

4.1 Planned and Unplanned Absence Allowance (PUAA) refers to periods of absence from work, which can be described as anticipated and, therefore, must be factored into the workforce planning process. This comprises annual leave, sickness[30], andmandatory study leave.

4.2 It is acknowledged that PUAAs are included in current funding within HSC Trusts ranging from 18% to 23%.

Rationale

4.3 Telford (1979)[31] remains the extant nurse workforce planning tool in use in Northern Ireland and the United Kingdom. This methodology recognises the need for 'allowances and amendments for sickness, absence, holidays, in-service training and nursing education'[32] in any method of effective workforce planning.

4.4 In 2006, the Royal College of Nursing recommended a PUAA of 25%[33]. Similarly, the Healthcare Commission recommended a minimum of 24% in 2005[34], prior to the implementation of Agenda for Change[35].

4.5 Other professions have reflected a requirement to build in allowances for planned and unplanned leave. For example, the medical profession referred to the necessity of 'supporting professional activities' within the Consultant Contract Framework (2003)[36].

Professional activities were identified as: training, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local governance activities. Leave is also directed to be built into weekly job planning for consultant teams, including an average of 10 days per year of professional activity[37]. It should be noted that sickness absence was not accounted for within the framework.

4.14 This agreement should enable discussions between commissioners and service providers to take place in relation to workforce planning for the future.

 Exhibit 7

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

Note of Hospital Modernisation Meeting

held on Friday 9 January 2015

in Cranfield Meeting Room, Muckamore

Present:

Mr J Veitch, Co-Director of Learning Disability (Chair)
Mrs E Rafferty, Service Manager of Hospital Services
Dr C Milliken, Clinical Director
[redacted], Consultant Psychiatrist
Mr B Mills, Clinical & Therapeutic Service Manager
Mrs F Davidson, Service Improvement Manager
[redacted], Consultant Psychiatrist
Ms A Morrison, Service Manager
Mrs A Dunn, Northern Trust
Mr I Eilian, HSCB
Ms R O'Neill, South Eastern Trust
Ms C Wilson, Southern Trust
Dr K Cousins, Specialist Registrar

Apologies:

Ms N McComiskey, Southern Trust
Mr B Ingram, Business & Service Improvement Manager
Mrs M Mitchell, Senior Manager of Service Improvement & Governance
Mrs R Harkin, Co-Director Western Trust
Mrs C Veitch, South Eastern Trust

WELCOME AND INTRODUCTIONS

Mr Veitch welcomed everyone to the meeting, introductions were made.

Mr Veitch gave the background of this meeting to the group. He explained that the overriding issue is to try and have a vision of the Hospital exclusively meeting the needs of Learning Disability Patients needing assessment and treatment. A number of internal meetings have previously taken place looking at trends and patterns of admission to the hospital.

Mr Veitch reaffirmed the Terms of Reference of the group.

PRESENTATION RE BACKGROUND AND CURRENT PLANNING ISSUES

Mrs Davidson gave a presentation on the background and current planning issues to the group.

Mrs Davidson highlighted Out of Hours admissions which are not all unplanned admissions and this could have a knock on effect on future configuration.

On the basis of a review undertaken by medical staff there is 80% of admissions that could be potentially avoidable if there was the right infrastructure in the Community across all 3 Trusts.

55% of safeguarding incidents involves Delayed Discharged or PTL patients. For two patients we've had to create independent living arrangements and due to this the incidents have reduced. Mr Veitch highlighted that we are having to create a Social Care Setting within this Hospital. It is a moving changing situation and we would not be able to sustain that without the Board's support for funding both a hospital and a broad range of social care placements on the site.

Mr Veitch spoke about Workforce Review and how the lack of revenue funding for skill mix prevented full hospital services.

Mrs Rafferty has raised the issues of Nursing Workforce and AHP's with Molly Kane and the PHA. Mr Veitch added that this has also been raised on a number of occasions with the HSCB through routine meetings.

Mr Veitch spoke about Skill Mix and how future input of professional skill mix and staff is also now being highlighted by the RQIA through Inspection process and was a key issue in relation to planning future hospital services.

Mr Veitch thanked Mrs Davidson, Mr Ingram for the exceptional work preparing the presentation, which will be circulated to the group following this meeting.

UPDATE ON INDIVIDUAL TRUSTS' COMMUNITY INFRASTRUCTURE ENHANCEMENT AND DEVELOPMENT

Mr Veitch spoke about how 14/15 is the final year for funding through IPT. Mr Veitch noted that Mr Murray recently confirmed funding for 2014/15. Once that is available we will proceed with drawing up a the remaining required Skill Mix for the Community Infrastructure.

Ms Morrison updated the group on Belfast Trust's position.

Ms Morrison spoke about plans for four community teams, they will include Social Work and Nursing Care Professionals and a range of other professionals, Occupational Therapy and Speech and Language, we are moving toward psychology into teams and Behaviour Nursing within teams. We've also strengthened Allied Health Professional resources within teams, we want to strengthen these up with Mental Health pressures and Challenging Behaviour pressures. Ms Morrison hopes it will be a preventative

service, which will then be backed up by Psychological Therapy Service and re-modelled Behaviour Services. Challenging Behaviour and Mental Health management – Ms Morrison explained that this will be a rapid response team with a potential on-call model. Mr Veitch feels the issue with that is existing staff and existing contracts. Ms Morrison explained that the team will be led by Consultant Psychologist and a Team Leader has been appointed.

Mr Veitch spoke about this year's funding, when confirmed, we get all the job descriptions ready to complete this infrastructure urgently, he asked Ms Morrison to link in with Dr Milliken. **ACTION:** Ms Morrison

Mrs Dunn updated the group on the Northern Trusts position.

Mrs Dunn explained that they are looking at 3 community learning disability teams with Social Work, Nursing, Occupational Therapy as core components. Psychology input, Behaviour Support is additional. Mrs Dunn will confirm funding with Mr Murray as she feels Northern Trust didn't receive the same as the Belfast Trust i.e. funding for years 2 and 3. Mr Veitch explained that Muckamore has to take the decision to start being a Hospital and stop admitting people who should be accommodated in Social Care settings. Mrs Rafferty feels that if all Trust areas are not developing their Community Infrastructures at the same time then it won't improve the patient journey and will lead to ongoing inappropriate admissions.

Ms O'Neill, updated the group on the South Eastern Trust's position.

Ms O'Neill noted that her Trust is hoping to develop something similar to Belfast Trust's model. They are also looking the provision of Step up/Step down beds which could help with prevention of admission to Hospital.

It was agreed that the plans regarding the Community Infrastructure should be shared and this would be helpful in planning for the future hospital needs. Ms O'Neill will report back accordingly.

IDENTIFICATION OF ANY OUTSTANDING INFORMATION/DATA REQUIREMENTS

Mrs Rafferty made reference to the community information and in particular the cases that we have identified where the admission could have been prevented. Mrs Rafferty will break this down by name of patient and share with each Trust. H40 feels that this could be a starting point for Trust's Community Infrastructure Planning as the teams will need to be tailored to meet the needs of these people.

STAFFING AND SKILL MIX REQUIRED FOR MODERN HOSPITAL

It was noted that no Occupational Therapy posts have revenue funding and this has been highlighted to the Board. Mrs Rafferty informed the group that she has carried out a piece of work with OT and 5wte would be required across a range of bandings/skill set. This is consistent with the national norms.

In relation to Speech & Language, there is 1wte post spread across all wards. It was agreed that this will require further investment. Speech and Language is vital.

There is also a very limited Physio resource of 1wte for the Hospital. Dietectics is only 0.4wte.

Behaviour Nurse – 2 wte funded posts for the whole hospital.

Psychology – 1 wte for forensic patients and for the rest of the Hospital we have an additional 1wte. H40 highlighted importance of this element of skill mix.

Social – 1 wte Senior Social Worker and 2 wte Social Workers for the whole hospital limiting which is limiting. The majority of time is taken up by Mental Health Review Tribunals and VA processes. There is a need to develop therapeutic social work support.

Mrs Rafferty also spoke about how Nursing Ratios within Core Wards are not at Therapeutic Levels. Molly Kane (PHA) has agreed to look at this. Mr Veitch spoke about the Cost Pressures and how they are currently the equivalent to 3 million per annum due to specialising requirements.

H40 spoke about the Medical Team and how H30 new appointment will make it 2.5 wte Consultants for the 87 beds compared to Mental Health where they have 3 Consultants for 37 beds in Knockbracken and in Beechcroft there is 1 Consultant for 8/9 beds. Mr Veitch explained that this has been raised by RQIA and it is something we have to formally highlight as a skill mix pressure. Mr Veitch also acknowledged that in strengthening Community Infrastructure the Consultant input will be very important.

The group noted the community infrastructure development within the Southern Trust. Mrs Rafferty will contact Noreen McComiskey re Bluestone and open it up to the Northern and Western Trusts to discuss their services.

It was suggested the name of the Hospital may be a consideration when we move to the new Treatment and Assessment service.

ANY OTHER BUSINESS

Next Meeting

Mr Veitch emphasised the importance of having the right people from other agencies at the next meeting so they can make decisions.

DATE, TIME AND VENUE OF NEXT MEETING

Friday 6 March 2015 at 2.00pm in the Boardroom, Admin Building, Muckamore.

Exhibit 8

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

Note of Hospital Modernisation Meeting

held on Friday 6 March 2015

in Boardroom, Admin Building, Muckamore

Present:

Mr J Veitch, Co-Director of Learning Disability (Chair)
Mrs E Rafferty, Service Manager of Hospital Services
Dr K Cousins, Specialist Registrar
Dr C Wilson, Belfast Trust
Mrs A Dunn, Northern Trust
Mrs C Veitch, South Eastern Trust
[redacted], Consultant Psychiatrist
Mrs M Mitchell, Senior Manager of Service Improvement & Governance
Mrs F Davidson, Service Improvement Manager
Mr I Eilian, HSCB
Dr C Milliken, Clinical Director
[redacted], Consultant Psychiatrist
Ms R O'Neill, South Eastern Trust
Mr A Walsh, Health & Social Care Board
Mrs M Kane, Health & Social Care Board
Ms N McComiskey, Southern Trust

Apologies:

Mr B Ingram, Business & Service Improvement Manager
Mrs R Harkin, Co-Director Western Trust
Ms A Morrison, Service Manager
Mr B Mills, Clinical & Therapeutic Service Manager

PREVIOUS MINUTES

Minutes of previous meeting held on 9th January 2015 were agreed.

RECAP ON PROGRESS TO DATE

Mr Veitch made reference to the Terms of Reference of this group and the importance of completing this project within the forthcoming months. This will however require the discharge of all current service users in quasi social care placements on the hospital site including the remaining PTL patients and the additional significant group of delayed discharges. Funding to achieve this will be essential for this group to continue to have a purpose.

Mr Veitch also made reference to the original business case prepared some years ago which envisaged a core hospital of 87 beds. This no longer appeared to be an appropriate model as no more than 40 patients have been in active assessment or treatment at the hospital in recent years. The final configuration will however have to be determined and informed by the robustness of the Community Care and Treatment infrastructures within referring Trusts and in particular Belfast, South Eastern and Northern Trusts.

SUMMARY BY TRUST OF REMAINING PTLS AND FUNDED/UNFUNDED DELAYED DISCHARGES

Mrs Rafferty informed the group that currently the hospital continues to accommodate 38 PTL patients, 16 are Belfast Trust, 10 are Northern Trust, 11 are South Eastern Trust and 1 is Southern Trust. Mrs Rafferty noted that while final discharge for some Belfast patients were delayed as far forward as June 2016 concrete plans are in place for all those remaining on PTL list.

Belfast Trust has 5 funded Delayed Discharges and 11 unfunded Delayed Discharges.

H40 noted that there is now another 4 patients fit for discharge within the hospital and this will have to be factored into Trust figures following this meeting.

It was agreed that each Trust should continue to liaise closely with the HSCB through Mr Murray and Mr Walsh to correlate available funding through PTL and complex needs streams against these patients and identify cost pressure in relation to the HSCB and Trusts' imperative to meet their statutory responsibilities.

DETAILED UPDATES FROM TRUSTS REGARDING COMMUNITY INFRASTRUCTURE IPT INVESTMENTS TO DATE AND REMAINING PLANS FOR ADDITIONAL 2014/15 FUNDING

Mr Veitch and Mr Walsh referred to the substantial 3 year investments through the IPT processes which had been made available to each Trust and the expectation and requirement for full and effective investment to facilitate the modernisation of Muckamore Abbey Hospital, end and prevent further social care placements on this site and facilitate the assessment and treatment of patients requiring hospital care.

For the Belfast Trust Mr Veitch confirmed that the total investment over the 3 years was being deployed to enhance Multi-disciplinary Community Care and Treatment Services including the provision of Senior Medical and Psychological Services. Final recruitment was now being completed and it was also anticipated that an enhanced Hours Service will be in place during the Autumn 2015.

For the Northern Trust Mrs Dunn noted that some clarification remained outstanding in relation to their 2014/15 IPT investment. Mrs Dunn indicated that this should provide a focus on challenging behaviours and there were also plans in place for an additional bed at Woodford.

For the South Eastern Trust Mrs Veitch indicated plans were being put in place for this finance will be deployed for the purposes highlighted in their IPT submissions to the HSCB and they were currently in discussion with Finance colleagues regarding this.

Mr Veitch and Dr Milliken emphasised the importance of full investment by all Trusts particularly the Belfast, South Eastern and Northern of this Community Care and Treatment funding as quickly as possible to prevent further and repeated inappropriate social care placements on the hospital site thus negating any prospect of hospital modernisation for the foreseeable future. Mr Eilian indicated that from the HSCB perspective he was satisfied from information available to him that all Trusts were satisfactorily addressing this agenda. Mrs Kane indicated that in the event of any concern regarding this matter she would be pleased to follow up and provide and necessary support.

Some discussion also focused on the development of the Community infrastructure within the Southern Trust and Ms McComiskey provided detailed information on this and reinforced the importance of this in preventing inappropriate hospital admissions. She would be pleased to facilitate any visits to these services in the Southern Trust if others thought that this would be useful.

Given the potential concern highlighted Mr Walsh indicated that following this meeting he would seek detailed information from his Accountant colleagues in each of the 3 Trusts regarding the investments made to date in relation to the additional Community Care and Treatment funding which had been provided by the HSCB. This, if necessary, can be the subject of further discussion/clarification at future meetings. It was agreed that each Trust would also provide further detailed information on their local investments at the next Hospital Modernisation meeting.

ANALYSIS AND DISCUSSION REGARDING PREVENTABLE SOCIAL CARE ADMISSIONS

A qualitative analysis summary of admissions during the period August – November 2014 was circulated and Mrs Davidson provided a brief presentation. It was noted that a further analysis of the source of readmissions would be helpful and hospital staff undertook to review this. H40 also highlighted concerns regarding inappropriate crisis admissions occurring out of hours through the involvement of ASWs and GPs and queried whether there may need to be additional training initiatives surrounding this.

Some concern was also expressed that the continuation of inappropriate social admissions to Muckamore may also be creating additional subsequent requirements for high cost alternative community placements which could be prevented and thus have a positive impact on longer term budgets. This again reinforced the urgency and critical importance of effective and urgent Community Care and Treatment Services being operationalized immediately within Trusts. Within this context it was noted that only 43 patients at Muckamore are currently in active treatment which compares with an average of between 35-38 in recent years. This was the subject of extensive discussion.

STAFFING AND SKILL MIX FOR FUTURE CORE HOSPITAL

Some discussion focused on continuing and increasing concern regarding the current skill mix at Muckamore to function as a modern hospital. This was also an issue which was now being highlighted repeatedly through RQIA Inspections and Improvement Plans in response to which the Trust did not have the available revenue funding to respond adequately.

Issues which had been highlighted and remained sources of acute concern included the inadequate Consultant sessions available to the hospital and the inappropriate skill mix between Band 3 and registered Nurses in response to which Mrs Rafferty and Mrs Kane indicated that they were already involved in analysing and seeking to address from their professional perspective. It was however acknowledged that in order to do so may require significantly additional funding rather than any anticipated savings through the elimination of social care placements. Dr Milliken also noted e.g. that H40 H40 currently had responsibility for 29 inpatient beds which was at extreme variance with Royal College expectation but also compared extremely unfavourably with practice elsewhere within Learning Disability / Mental Health Services across Northern Ireland. This also reflected the existing pressures within community outpatient work across the Belfast, South Eastern and Northern Trusts. It was therefore essential that all Trusts in enhancing their Community Care and Treatment infrastructures gave full cognisance to this reality.

Very significant concern had also been raised regarding the inadequacy of AHP and Psychology Services available to hospital patients. Again this was also a major issue for RQIA to which the Trust cannot currently respond positively in the absence of the required revenue funding and presented a real threat of "Failure to Comply Notices". At present other than short term commissioned Occupational Therapy resource for Resettlement there is no revenue funding for any Occupational Therapy for patients in assessment/treatment. Speech and Language and Psychology inputs were also recognised as piecemeal and inadequate and would require significant additional investment in order to meet minimum standards. This was particularly significant as the Trust is currently seeking accreditation by QNIC (Royal College Quality Network for Inpatient Care) but it was recognised that such accreditation would not be achieved without significant enhancement of multi-disciplinary skill mix within the hospital.

In relation to this issue and also the broader context of the interface between hospital and community services Mr Veitch indicated that over the next number of months the Trust planned to undertake a "benchmarking" exercise which will inform not only the work of this group but the broader planning context.

ANY OTHER BUSINESS

Some discussion focused on the current and acute pressures within the hospital of having to manage a predominately social care population for whom bespoke care placements were having to be provided alongside a smaller number of patients receiving assessment and treatment. Risk management considerations prevented these two distinct group of service users being managed in separate physical environments. This continued to be detrimental and at times potentially harmful to the individuals concerned and impacted on treatment duration and outcomes.

Dr Milliken also noted the work currently being commenced in relation to a Regional Bed Protocol which also have to be considered and factored in to the final recommendations of this group.

DATE, TIME AND VENUE OF NEXT MEETING

Friday 19 June 2015 at 2.00pm in the Boardroom, Admin Building, Muckamore.

 Exhibit 5912

BELFAST HEALTH AND SOCIAL CARE TRUST

MUCKAMORE ABBEY HOSPITAL

Note of Hospital Modernisation Meeting
held on Friday 19 June 2015
in the Boardroom, Admin Building, Muckamore

Present:

Mr J Veitch, Co-Director of Learning Disability (Chair)
Mrs E Rafferty, Service Manager of Hospital Services
Dr K Cousins, Specialist Registrar
Mrs S Shepherd, South Eastern Trust
Mrs A Dunn, Northern Trust
Mr I Eilian, Health and Social Care Board
Mrs E Rafferty, Service Manager, Hospital Services
Mrs M Mitchell, Senior Manager, Service Improvement & Governance
Mr B Mills, Clinical & Therapeutic Services Manager
[redacted] H30, Consultant Psychiatrist
Dr P Ling, Speciality Registrar
Ms A Morrison, Service Manager
Mrs C Veitch, South Eastern Trust

Apologies:

Mr A Walsh, Health and Social Care Board
Mrs M Kane, Public Health Agency
Mr B Ingram, Business & Service Improvement Manager
Mrs F Davidson, Service Improvement Manager
Dr C Milliken, Clinical Director

PREVIOUS MINUTES

Minutes of previous meeting were held on 6 March 2015 were agreed.

SUMMARY BY TRUST OF REMAINING IPTS AND FUNDED / UNFUNDED DELAYED DISCHARGES

Mrs Veitch noted that the South Eastern Trust has 5 PTL patients left who all have plans for around September 2015. They have currently 10 delayed discharge patients and Mrs Veitch plans to meet with Mr Walsh, Health & Social Care Board to confirm funding available for the delayed discharge population.

Mrs Dunn informed the group that the situation with the Northern Trust is very much the same. Mrs Dunn confirmed that they are aiming for Autumn 2015 for placement of the Northern Trust remaining PTL population. Mrs Dunn also indicated that she would check and confirm funding arrangements and plans for the delayed discharge population.

Mrs Rafferty noted that of the remaining 18 Belfast Trust PTL patients all plans are in place but final discharge had been delayed for a significant number by the timescales for Dympna House and the procurement of Nursing Home placements in the continuing absence of regional procurement and tendering arrangements. Plans were however progressing for the other PTL patients to be discharged during the Autumn to identified placements (both Supporting People and Nursing Home). Mr Veitch again highlighted the Trust's concern regarding the limited funding available to expedite the discharge of the growing and significant population of the delayed discharges now in excess of 40. While welcoming additional investment in-year this was far from adequate at present to address this issue and funding was confined to children transitioning, older carer pressures and limited funding to each Trust for complex needs. Unless resolved this will continue to leave Muckamore Abbey Hospital as a significant social care campus with a minority of patients receiving treatment and will negate the possibility of this planning group making any progress. It was acknowledged that at some point these issues may have to be more robustly escalated.

DETAILED UPDATES FROM TRUSTS REGARDING COMMUNITY INFRASTRUCTURE IPT INVESTMENTS AND TRUST REVIEWS OF PATIENT PROFILE INFORMATION

Ms Morrison confirmed that the Belfast Trust had now invested the totality of the significant additional funding provided through IPTs from the Board although some posts were still in recruitment phase. Successful applicants should however be in post by the early Autumn. This investment recognised the important role of community teams in supporting service users and preventing inappropriate hospital admissions and therefore there had been some additional investment in skill mix and care management including some additional psychology investment. Investment had also been directed to an intensive support team and additional specialist behaviour support and plans were in preparation for the piloting of an out of hours service initially to 8.00pm around November 2015. Ms Morrison also noted that the funding and recruitment of an additional full time Consultant Psychiatrist was a key component in strengthening community care and treatment services.

Mrs Dunn informed the group that investment within the Northern Trust has taken longer to plan and the resettlement team is continuing to focus on this work. It was also noted that some finance has been identified for respite and there were longer term plans to develop a support team which would assist with crisis situations. There were also posts proposed for recruitment at Band 3 and 5 levels and one additional Band 7 post. Plans to develop an out of hours service were at an early stage but there was a possibility of investing some finance to supplement the RAID service which currently has a primary focus on Mental Health. Mrs Dunn confirmed that at present the Trust had not identified a requirement to deploy additional funding towards the supplementation of community psychiatry.

Mrs Veitch noted that the South Eastern Trust has a tiered approach similar to Belfast Trust's community teams. The Trust is deploying additional investment in care teams, speech and language therapy and behaviour support. They are also looking at the option of recruiting Band 5 support workers who could be deployed to patients' homes

including, if necessary, care settings. The use of a bed in Struel Lodge is also being reviewed in relation to a potential step up step down service. At present the South Eastern Trust has no current plans to deploy finance towards strengthening community psychiatry.

PREVENTABLE SOCIAL CARE ADMISSIONS AND NATIONAL BENCHMARKING REFERENCE HOSPITAL AND COMMUNITY SERVICES

Mr Veitch referred to the previous presentation and discussion regarding the pattern of preventable admissions and that in order to achieve the modernisation of Muckamore Abbey Hospital there needs to be a point at which all "social care" admissions are adamantly refused and referred back to the enhanced community care and treatment structures within Trusts. Considerable discussion ensued which highlighted the importance of changing the perception of the hospital as a place of safety for learning disabled people when community services fail or are inadequate. It was acknowledged that as part of this process there needed to be more effective and robust engagement with ASWs and General Practitioners. There also required to be a much firmer and consistent approach with voluntary and independent providers referenced to their contractual obligations both to service users and commissioning Trusts. Within this context it was noted that many inappropriate requests for admission related to the management of challenging behaviours.

Mr Veitch noted that in order to assist with these challenges this group needed to undertake effective benchmarking with similar services elsewhere. Mrs Rafferty made reference to the planned engagement of the hospital with QNIC with reviews planned from October 2015. This should not only assist with benchmarking but also provide an assessment against national standards and progress. It was however again noted that these issues could only begin to be satisfactorily addressed when all PTL and delayed discharge populations have been finally discharged.

STAFFING AND SKILL MIX FOR FUTURE CORE HOSPITAL

It was again noted that the funded skill mix at Muckamore Abbey Hospital was not fit for purpose for a modern hospital.

In relation to nursing Mrs Rafferty, in consultation with Mrs Kane, continues to work on reviewing the skill mix which currently is 50:50 qualified and unqualified. This is work in progress but an acceptable standard would likely represent 70:30. This however must be aligned to local and national professional standards and expectations.

There were similar issues in relation to psychiatry with approximately 2.0 wte within the hospital which bore no resemblance acceptable standards within Mental Health and Learning Disability services elsewhere regionally. Mr Veitch confirmed he had asked Dr Milliken to prepare a brief paper highlighting these concerns with reference to similar local services, college guidelines etc. Current pressures were significantly exacerbated by social care admissions, associated challenging behaviours and the extremely detrimental effect of social care placements having to be managed alongside patients requiring acute assessment and treatment.

In relation to other funded skill mix within the hospital it was noted that:-

- In additional to a specialist forensic psychologist there is a total of 1 funded psychology post for the hospital.
- Occupational therapy has no funded establishment at all for the hospital with current input funded short term and confined specifically to community integration.
- Funded physio establishment for the totality of the hospital is 0.8 wte, funded dietician is 0.4 wte and a total speech and language funded input of 1.6 wte.
- There is zero funded pharmacy assigned to the hospital.

Some discussion also focused on current staffing pressures within the hospital caused by the current configuration of people being accommodated on the site. Mrs Rafferty outlined the extent of these pressures and continuing proactive and robust strategies being deployed to achieve an improvement. This was also representing a very significant cost pressure which was having to be addressed in partnership with the Board on a rolling basis.

Reference was also again made to the hospital's concern regarding the continued failure to comprehensively address the clear discrimination effecting those people living at Muckamore in relation to primary care services. Within this context it was again noted that those living at Muckamore for over 6 months are automatically removed from their GP's list and that while the Trust has been proactive in providing a uncommissioned GP out of hours service this did not afford access to full range of primary health services. It was agreed that this also remained a human rights issue which remained unresolved despite strong and persistent representations from the Trust for this commissioning gap to be addressed. Mr Eilian agreed to again bring this issue back to the Board and PHA for further discussion and report back as quickly as possible.

FUTURE BED REQUIREMENTS AND WARD CONFIGURATION

Mrs Rafferty reported that at present there are approximately 120 service users resident at Muckamore with approximately 40 receiving treatment. Regrettably if this position remains unresolved it will prevent the closure of 2 resettlement wards originally planned for March/April 2015. It was agreed that our next meeting should focus on the outcome of the benchmarking referred to above in order to inform decisions regarding the future configuration and staffing of the hospital.

DATE, TIME AND VENUE OF NEXT MEETING

Friday 27th November 2015 at 2.00pm in the Boardroom, Admin Building, Muckamore

 Exhibit 10

Templer, Sara

From: Veitch, John <John.Veitch@belfasttrust.hscni.net>
Sent: 07 August 2015 15:01
To: Aidan Murray (Aidan.Murray@hscni.net); molly.kane@hscni.net
Cc: McNicholl, Catherine; Kerr, Hayley; 'Dunn, Alyson'; Crilly, Miceal (Miceal.Crilly@southerntrust.hscni.net); 'Veitch, Carole'; Harkin Rosaleen (rosaleen.harkin@westhealth.n-i.nhs.uk); OKane, Maria; Milliken, Colin; Rafferty, Esther; Morrison, Aine; Mitchell, Mairead; Harris, Lesley
Subject: FW: Bed Pressures Muckamore

Aidan / Molly

I regret to have to alert you again to the ongoing bed management pressures within the adult inpatient services at Muckamore Abbey Hospital, with particular reference to Core Hospital wards providing the acute admission service. At time of writing, and despite every effort being made to utilise available community resources to prevent admission and the use of every available inpatient bed, there are currently no beds available to facilitate any immediate admissions or to safely consider any additional capacity. Regrettably these difficulties appear to be primarily caused by the lack of movement of delayed discharge patients.

As you will be aware t here are currently 42 delayed discharge patients in addition to the remaining PTL population currently awaiting community placements who are accommodated across all wards within the hospital. While plans are being developed for some of this group there remains a significant number in respect of whom no funding is currently available to facilitate discharge. The consequent impact is that a finite total of 35 beds is available for assessment and treatment.

Recently an extremely high number of service users are being presented almost on a daily basis for detained admission to the hospital and currently pass beds and on occasions sleeping out arrangements are having to be deployed to try to maintain a safe environment. Planned or non urgent admissions for medication changes or observation are having to be declined or deferred and in a number of incidents this is leading to crisis situations, additional pressures on carers and families and when admitted longer periods in hospital or possible detentions which could have been avoided. This pressure has increased significantly in recent weeks despite continuing routine discharges.

You should also be aware that Trust and Board representatives did recently meet as a regional group to explore a bed management protocol but consensus was that there are enough beds to manage our own pressures locally if delayed discharge patients received the same or similar level of priority that is currently afforded to the PTL population under the community integration project. It was also acknowledged that moving patients to another acute admission unit regionally was not desirable and would not for many patients provide a person centred or risk free solution.

Regrettably I have now been advised that the hospital has reached the point that it cannot at present safely facilitate any additional acute admissions pending an easement in the current bed pressures. We would therefore appreciate your urgent advice/comments and you will note that I have also shared this correspondence with colleagues in other Trusts as I suggest that in the immediate future there needs to be a regional approach to managing admissions when such an admission cannot be avoided.

We shall, of course, ensure that this issue remains the subject of close and continuous review and advise you immediately of any change in circumstances. Esther, Colin or I would be pleased to discuss further or provide you with any additional information required.

John
