ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Mairead Mitchell
Date: 25th April 2024

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

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

This is my first statement to the Inquiry.

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

Qualifications and positions

1. I qualified as a Registered Nurse in 1978, a Registered Midwife in 1980 and Health Visitor in 1983.

2. I have held the following positions:
    - Assistant Director of Quality in North and West Belfast Trust from 1997 – 2005.
    - Assistant Director of Service Improvement and Modernisation, Learning Disability Directorate North and West Belfast Trust from 2005-2007.
    - Senior Manager Service Improvement and Modernisation in Adult Social and Primary Care Directorate Belfast Trust from 2007- 2016.
    - Head of Learning Disability Services Belfast Trust from 2016 – 2019.

Module

3. I have been asked to provide a statement for the purpose of M7 MAH Operational Management.

4. My evidence spans across the Inquiry's Terms of Reference.

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

Questions for witnesses working in a management position at MAH

Q1. Please explain what your role was in the management of MAH and when you held that role? In doing so, please explain:

i. the cohort of staff for which you had leadership and/or management responsibility;

ii. the day to day responsibilities of your role.

6. In 2005-2007 my role as Assistant Director of Service Improvement and Modernisation Learning Disability Directorate, North and West Belfast trust, was to lead the new build of the two hospital projects both for Adults and Children and to support and advise the management team within learning disability on service improvement.

7. In 2007 my post changed to Belfast Trust and covered a number of service areas within the Adult and Social and Primary Care Directorate, including Older People services, Mental Health and Learning Disability.

8. I took up post as Head of Learning Disability services in December 2016. This post was to oversee the management of Learning Disability adult and children services within the Belfast trust area. This included Muckamore Abbey Hospital. At that time the Trust was proposing to amalgamate mental health and learning disability services under one management structure.

9. I had responsibility for the £50 million budget and the staffing compliment was approximately 800wte across Learning disability services.

10. At my appointment the management structure in learning disability services was depleted due to the funding for previous management posts not being available. I

had two service managers who reported to me, one covered Hospital services which included Muckamore and Iveagh children's unit and also Residential and supported living services in Belfast.

11. The second service manager covered daycare services, social work including safeguarding and community services provided by teams. Previously there would have been three service managers for Learning Disability services.

12. Day to day my role was to guide the service through changes that were planned for the service, provide a leadership role for staff within the service, manage the budget, and to look at the development of community services with the changing environment of hospital-based care for people with a learning Disability. My role also involved engaging with the other Trusts in Northern Ireland, the Health and social care board and voluntary and community organisations in developing future services for people with a learning disability.

Q2. If you had a role in the admission and discharge of patients to MAH, please explain:

i. **How patients were referred for admission.**
ii. **Who was involved in the referral process.**
iii. **What factors impacted whether someone was able to stay at home or in the community or whether they were referred to MAH.**
iv. **Specifically, did lack of resources or delay in availability of support in the community impact on whether a patient was referred to MAH? If so, please explain.**
v. **Were other options to enable someone to remain at home or in the community always explored prior to the decision to admit them to MAH?**
vi. **How was it decided when a patient was ready for discharge from MAH?**
vii. **Were there patients at MAH for whom discharge was never considered? If so, why?**

13. My role was to work with the other Trusts and voluntary and community organisations to try and expedite the discharge of patients to appropriate services for their needs. I was not involved in individual discharges unless there was an

issue that may have needed my guidance or help. The hospital and community teams worked together to process the admission and discharges.

14. I also chaired a resettlement meeting with engagement from the other trusts and the health and social care board to discuss the number of patients from each trust due for discharge and to discuss funding.

15. There were no patients for whom discharge was never considered.

Q3. How regularly did management meetings take place at MAH? Who set the agenda for any such meetings? Were minutes always kept of such meetings?

16. The service manager had regular meetings with the heads of departments, regular ward managers meetings and she attended the Core group meeting which was weekly.

17. After I took up post, I changed the format of the core group meeting to include community services. I also invited finance, HR and governance on a regular basis. The meeting was weekly, and minutes were taken.

18. I also had one-to-one meetings with the individual service manager monthly. These were not minuted but notes taken for action.

19. I also had one to one meeting with the medical director for MAH monthly.

20. I also chaired a monthly Quality Forum where staff presented good practice from their wards/departments.

Q4. Did MAH managers receive regular reports on:

- **i. The use of seclusion.**
- **ii. The use of PRN medication.**
- **iii. The use of physical intervention including MAPA.**
- **iv. Safeguarding.**
- **v. Complaints.**

21. If yes, please explain who prepared any such reports and how any concerns identified from the reports were escalated.

22. Regular reports were received by senior managers and the ward managers which included all of the above as well as incidents/accidents and patients on special observations on a weekly basis. These were discussed at the core group meeting and latterly at the combined hospital/community management group meeting. These reports were also sent to the consultants for learning disability.

23. These reports were collated from a data system by the hospital resource nurse. The information in the reports had been sent to the system by wards and departments. The reports were extremely useful and discussed weekly at meetings. Any concerns, issues or queries were referred to the service manager for reporting back. On occasions the report was reviewed to include extra information.

24. These reports would also have been regularly shared with the director, and information from them would have also been provided to other trusts and the HSCB.

Q5. What procedures or processes were in place to ensure co-production between MAH staff and relatives of patients at MAH?

25. In 2016 when I took up post, there was little evidence of co production between staff and relatives. There were meetings with relatives about care and treatment, but this was information giving by ward staff and not co production. The parents and friends' group of the hospital did not appear to have a role or have regular meetings with management.

26. At the beginning of 2017 I set out a plan for co production within the hospital setting which was already under way in the learning disability community services. This involved securing funding for a User Consultant to support the process and encourage involvement from relatives.

Q6. What procedures or processes were in place to ensure co-production between MAH staff and community teams?

27. Community teams were actively involved at MAH regarding the resettlement process and worked with ward staff and families to ensure the needs of the patient were aligned to the discharge plan. As part of this process community and voluntary organisations were also involved.

28. At a management level monthly meetings were held with the voluntary and community groups and included community and hospital staff to plan the way forward for patients in the hospital who were to be discharged.

29. The Quality Forum also enabled hospital and community staff to share information and good practice.

Q7. What were the arrangements for multi-disciplinary team working with patients at MAH?

30. Muckamore services were multidisciplinary and weekly ward meetings involved all disciplines involved with the patient. Patients on admission had a care plan and this outlined the care required and the needs of the patient. This was audited on a regular basis to ensure adherence to the care plan. All involved staff accessed the Datix system to input notes that could be shared.

Q8. What arrangements were in place at hospital level to monitor the implementation of and adherence to BHSCT policies by staff at MAH?

31. There were several tools used at MAH to monitor adherence to Belfast Trust policies.

32. A policy group was set up to look at policies and update them accordingly, they then went to core group/management meeting for approval before being presented at the Trust policy group for sign off.

33. These policies would then be distributed to staff and discussed at ward managers and the ward meetings.

34. The policies were also uploaded to the trust site for staff to access at any time.

35. Evaluating Quality Care (EQC) was an audit tool used in the hospital to determine adherence to a number of areas which included policies and procedures. The outcome of the audit was then presented to management and action plan drawn up. These action plans were then signed off when the actions had been completed.

36. The report on incidents/accidents, MAPA, etc also was used to determine if policies were being adhered to. If issues arose these were highlighted and one of the areas looked at was adherence to policies.

37. Complaints were also used as a monitoring tool for adherence to policies.

38. Management Walkabouts were introduced again in 2016 and included not only senior managers but senior staff from other services. This allowed for new eyes to monitor practice.

Q9. What were the arrangements for clinical supervision of the practice of staff across all disciplines (including healthcare assistants) at MAH?

39. All staff had induction at Trust, hospital and ward level.

40. Clinical supervision was at ward level by the ward manager who reported to the senior nurse manager.

41. Ward managers had monthly meetings with senior nurse managers and the service manager.

42. Other disciplines had their own arrangements for clinical supervision through their management structure.

43. The training strategy was also populated from outcomes of clinical supervision.

44. The trust had a policy for clinical supervision.

Q10. What were the performance management arrangements for all staff, including managers, at MAH?

45. Personal development plans were target driven for managers.

46. Delayed discharge was the main target for staff at MAH and this was aligned to each ward and discussed at ward meetings. Issues with the target was then brought to the senior nurse manager and the service manager for discussion.

47. The directorate had access to a performance manager who attended the management meetings and presented updates on adherence to the targets.

48. EQC at local ward level was a useful tool for staff to view each wards progress on targets.

49. Other ward targets related to hand hygiene audits, staffing and agency usage.

50. Learning disability services was also part of the NHS benchmarking network which compared services throughout the UK in relation to standards and patient outcomes.

51. As part of trust performance management financial savings were yearly targets,

52. The directorate management plan was developed under a number of headings which included targets on performance management.

Q11. What opportunities were available for the professional development of staff at MAH?

53. Staff had access to the trusts training programme and could apply for attendance at courses with the support of their line manager.

54. Professional development was part of each member of staffs one to one with their manager or supervisor.

55. Staff had access to courses at the universities, the Beeches management centre and other conduits for training.

56. Training strategies were drawn up trust wide for professions and then training leads supported service areas with training plans.

Q12. Did you have any role in workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? If so, please describe that role. Please also explain how any concerns about such matters were escalated.

57. When I took up post in 2016 there was already concerns at trust level about staffing levels with many staff were working extra shifts and Bank staff were employed to fill gaps in duty.

58. Agency staff were also being used to fill in gaps in staff rotas.

59. The service manager was responsible for the workforce monitoring and planning for MAH and to highlight issues to both line management and the Trust professional lead.

60. Workforce issues and concerns were brought to the core group and the learning disability management meeting as well as the directorate meeting.

61. There were regular meetings about the workforce within the trust Human resources department to help with recruitment and to look at other ways to recruit.

62. The issue of recruitment, especially of nursing staff, was an ongoing concern. It was highlighted at directorate and trust board level.

63. Discussions also took place with the training establishments to alert students to posts in learning disability.

Q13. Did MAH managers carry out regular data analysis and trend identification? If so, please explain how this was done.

64. A tool known as EQC evaluating quality care had been developed in the hospital over a number of years and was used as part of a multidisciplinary audit group. Wards and departments would be audited regularly against standards and the outcome and action plan shared with wards/departments. This was also shared with the management group and when the action plans were completed would be tabled at the meetings.
65. The weekly report for core group/management meeting looked at trend analysis and yearly a report was developed to highlight trends over the months and the years.

Q14. What arrangements were in place at hospital level to monitor the use of seclusion at MAH?

66. Seclusion would have been monitored at ward level by ward sister and consultant. As part of the policies, seclusion and special observation, a form was completed each time seclusion used and sent to hospital management for discussion.

67. Care plans were also audited twice a year and if seclusion was part of the plan would have been audited in relation to policies.

68. EQC audit tool also monitored seclusion by ward and was highlighted at core/management meetings.

69. The weekly report for core/management meeting also highlighted seclusion by patient and queries discussed with the medical director for learning disability who attended the meeting.

70. Psychology services were involved in development of the Seclusion policy and helping with training for staff. In 2016 positive behaviour support was introduced to try and reduce seclusion and physical intervention.

Q15. Please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at management level to address such concerns.

71. In 2017 was notified of incident viewed on CCTV which has led to this inquiry.

Q16. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

72. In December 2016, I was notified by RQIA of poor inspection of Erne Ward at MAH that required urgent attention and action. The ward had not addressed previous recommendations from RQIA 6 months prior.

73. February 2017, I received the first anonymous letter about how the hospital was being managed over previous years.

74. March 2017, several ward managers highlighted concerns about leadership on the hospital site.

75. Several subsequent anonymous letters were also received by the trust and the Department of health.

76. The director and I took a series of joint ward walkabouts early 2017 to discuss with staff concerns or issues that may need addressed in each ward.

77. From this a Task and Finish Group was set up chaired by myself and with representation from all wards to try and address the issues of concern.

78. Listening groups were also set up for staff where they could in confidence speak to managers outside of learning disability. A report on the main concerns from these listening groups was shared with managers and the task and finish group.

79. An action plan was developed, and this was the hospital plan for the way forward.

80. A series of workshops were held for staff detailing the outcome of the task and finish group and the way forward.

In addition, having regard to your role at the time of the investigation into incidents arising in Ennis Ward in and around November 2012, the Panel would be assisted if you would also address the following matters in your statement:

Q1. What was your role in BHSCT at the time of allegations which arose in relation to Ennis ward (November 2012)?

81. My role was not specifically for MAH. I was Senior Manager for Service Improvement Modernisation and Governance for the Directorate Adult Social and Primary Care, which covered older people services, mental health services and learning disability services across Belfast.

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

82. I was made aware by a phone call from the Director and was informed that it was to be managed as Safeguarding Vulnerable Adult process and it was being led by a senior Social Worker.

Q3. What was your role in the Belfast Trust's safeguarding investigation into the allegations made about incidents on Ennis ward on 08 November 2012?

83. I had no role in this process.

Q4. Why was a Serious Adverse Incident Report (SAI) not submitted in respect of Ennis? Please provide your recollection of the process that resulted the decision not to submit an SAI Report.

84. It would not have been my decision to submit an SAI. This was the role of the Director and the lead for the safeguarding investigation.

85. The safeguarding vulnerable adult procedure was different to the SAI procedure.

Declaration of Truth

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

Signed: *Mairead Mitchell*

Date: 25th April 2024

List of Exhibits (Mairead Mitchell)

Exhibit 1: Issues of concern re Muckamore dated July 2017.

Exhibit 2: Concerns re hospital services dated 7th November 2017.

Exhibit 1 MAHI - STM - 240 - 15

Issues of concern re Muckamore Abbey Hospital July 2017

July 2016	Erne Ward RQIA report. 12 areas for improvement ranging from basic fire safety, ward cleanliness and record keeping
August 2016	Detailed action plan to RQIA. John Veitch tried to implement the Quality Monitoring Tool that had already been implemented in other areas. Service Manager opposed to this.
August 2016	Ward Manager voiced concerns to John Veitch re leadership and communication. A Senior Nurse Manager had two meetings with John Veitch re concerns about the leadership and poor communication.
December 2016	RQIA re-visit to Erne Ward. RQIA very concerned as recommendations not implemented and cited poor leadership. RQIA had also concerns from relatives and staff. Staff have said no management support. RQIA findings, - No progress after 5 months. Considered special measures/Failure to Comply.
February 2017	- Relatives of patients contacted RQIA regarding patient safety in admission wards. - Parents and Friends Group requested meeting with Head of Learning Disability re patient safety. -
February 2017	- Received anonymous letter re issues concerning Service manager
March 2017	Email to Head of Learning Disability from two Ward Managers about concerns on wards. Patient safety, staff movement around wards and staff retention.
May 2017	1st visit of Director of Adult Social & Primary Care and Head of Learning Disability Service walk around to specifically speak to staff. - Wards visited Erne 1 and Erne 2, Cranfield 1 and 2. - Concerns raised by staff. Poor bedding and furnishings for patients in resettlement wards (Erne).

Poor communication with staff on why being moved.
Didn't know what the future of Hospital was
Poor Retention of staff.
Poor support from Senior staff

- Feedback was given to Service Manager.

May 2017

Consultant psychiatrist contacted Head of Learning Disability to highlight concerns regarding Service Manager following ward visits.

- Abrasive attitude.
- Poor communication.
- Treatment of staff.

July 2017

2nd walk around Director of Adult Social & Primary Care and Head of Learning Disability. Wards visited Sixmile, Killead and Donegore.

Concerns raised by staff

- Retention of staff.
- Ward Managers didn't know why staff were moved
- Staff unaware of future of Hospital.
- Wards work in isolation – no communication between wards.
- Lack of senior staff leadership.
- Upset staff on admission ward regarding high level of incidents and staff safety. Had highlighted concerns to senior staff but to no avail.
- Upset staff on another ward re movement from ward. No idea why. Ward Manager not aware either.

Feedback given to Service manager evident that previous feedback had not been taken on board.

MAH Absence Rates

Currently 10% and has ranged over the year from 9.9% to 10.30%

Target is 6.2%

Main issues
- Long term ill heath
- Mental health issues
- Stress

cidents

Number of incidents for the month of May 17 is **369**

279 of these are abusive violent behaviour both patient to patient and patient to staff.
46 of these resulting in staff injuries

- Recent incident on admission ward resulted in staff member fractured femur/hip replacement.

Incidents are up 2% from last month and up 6.5% in same period last year.

)mplaints

Families of patients have requested meetings with Head of Learning Disability regarding concerns about patient care and safety in admission ward. All complaints have been upheld and are about basic care and communication.

ıfeguarding
:idents

54 incidents in regard to safeguarding for May 2017
25 of these incidents are the admission ward where staff voiced safety concerns.

Occupational health referrals regarding service manager ER.

1, January 16 - outcome fit to work
2. July 16 - outcome fit to work.

Mrockrell.

Concerns re Hospital Service

2015/16	Previous Co-Director had concerns about Service Manager (ER). These concerns had been communicated to the then Director. I'm aware that one of the Senior Nurse Managers from Muckamore had a number of meetings with my predecessor about the Service Manager but I have no further information.
December 2016	I was just into post when RQIA alerted me to issues concerning Erne 1 and 2 wards. Previous concerns and recommendations from June 2016 had not been addressed and the ward was deteriorating. No Ward Manager and lack of leadership. RQIA were going to impose measures and a failure to comply. Trust had 24 hours to agree an action plan with them. I immediately moved the Senior Nurse Manager and put in a Senior Ward Manager to address the concerns. RQIA agreed plan. Service Manager was not happy with the plan but agreed to implement. Service Manager was unable to give explanation of why issues not addressed.
January 2017	In taking up my post I was very aware after a short period of poor relationships between the Service Manager, the Clinical Director and the Lead for Social Work. I made a number of changes to try and improve this and I also looked at the structure of Learning Disability Services. A Service Manager post was not replaced and both the Hospital Service Manager and Service Manager for Community had extra workload to cover the vacant post. I set about recruiting for this post and in May 2017 was able to relieve the two Service Managers of their extra duties/workload.
January 2017	Requested meeting with Director of Nursing as advised by my Director to discuss Muckamore and issues that I had. I had thought it was to be Director and myself but Director invited the Service Manager who was also the associate director for nursing. I discussed the staffing issues which related to retention and recruitment, poor RQIA report. Action for Service Manager was a Workforce Plan that was to be shared with me.

	Director of Nursing to do a leadership walk around at Muckamore.
February 2017	Anonymous letter to Director and myself about concerns in Muckamore and naming Services Manager. Meeting with Director of Nursing, Director of Human Resources and Director of Adult, Social & Primary Care to determine way forward. This was looked at under whistleblowing but did not meet the criteria. Director of Adult, Social & Primary Care and I discussed moving Service Manager but in discussions with Human Resources no evidence at this stage that would warrant a move.
March – July 2017	Meetings with Service Manager, myself and Central Nursing to provide support managerially and professionally. Meetings with Director of Human Resources and Director of Nursing with Director of Adult, Social & Primary Care and myself to discuss way forward. I have copied some of the notes of meeting previously to you.. Director of Adult, Social & Primary Care and myself did a number of walk abouts to talk to staff and determine if issues or concern.
July 2017	Further meeting with Director of Human Resources and Director of Adult, Social & Primary Care and myself to feedback issues and determine way forward. • Agreed to implement informal capability process. • External coaching for Service Manager • Formal meeting with Service Manager to discuss concerns with Director of Adult, Social & Primary Care and myself. Main areas of concern was in regard to leadership and management by Service Manager.
August 2017	Advice sought from HR re Service Manager applying for Divisional post while in the Informal Capability process.
September 2017	Service Manager appointed to Divisional Nurse for Learning Disability. Informal Capability procedure still ongoing at this stage.
October 2017	Ceased Capability process. Service Manager had complied with the action plan. Coaching still ongoing till November 2017. My concerns about leadership and management still exist and I do not believe the present process has adequately addressed this. The

	Service Manager, I believe, reacts to situations and does not plan the way ahead. This leads to a lot of tension, not thinking through situations and poor decision making. Staff engagement on Muckamore site has not been good. This is very evident from the Task and Finish Group I have set up to look at workforce issues, staff engagement and communication. I also believe the 8As are not working as they should be and when I've addressed this with the Service Manager, it is not seen as an issue. The culture of management on Muckamore site is controlling rather than engaging. I am awaiting on the outcome of the staff listening groups which have been done by Central Nursing and Governance and I will forward this to you..