# ORGANISATIONAL MODULES 2024

## MUCKAMORE ABBEY HOSPITAL INQUIRY
## WITNESS STATEMENT

**Statement of Esther Rafferty**
**Date: 27th June 2024**

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

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

This is my second statement to the Inquiry having previously provided a statement to the Inquiry dated 13 April 2024 (MAHI – STM – 229 – 1).

There are no documents produced with this statement.

**Module**

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

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

3. I am preparing this statement from memory and will do so to the best of my ability and recall.

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

**Q1. 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.**

5. I took up role of service manager for MAH on 02 January 2012. Alongside this post I was also the Associate Director of Nursing (Learning Disability) and this role was to be professional lead for LD nursing across Belfast Trust i.e. Hospital and Community Nursing.

6. As service manager I was managerially responsible for the nursing and social work / social care staff on site. I did not have management responsibilities for the medical staff, support services staff, administration staff, estates staff or AHP staff but did liaise and work along with their managers.

7. My role was to provide management and leadership to the inpatient services at MAH and Iveagh Centre, and lead on the resettlement agenda and work with the LD services management team lead by John Veitch, Co-Director to review and develop LD nursing and LD services to meet the needs of the patients in the community and hospital.

8. My responsibilities increased in 2016 when the Co-Director J Veitch had offered a service manager post up as efficiency savings reducing the service manager posts from three to two. I was asked to accept responsibility for half of another service manager responsibilities alongside the remaining service manager Aine Morrison.

9. I then held managerial responsibility for this on top of my existing responsibilities for Trust supported housing, residential care and community support services until July 2017.

10. The then Director Catherine McNicholl and Co-Director John Veitch both left their respective posts in 2016 I recall under Voluntary Early Retirement (VER) with Cecil Worthington becoming Director ASPC and Children Services and Barney

McNeaney becoming CoDirector for both mental health and Learning Disability Services.

11. In September 2017 I applied for and was successful at interview for the Divisional Nurse Learning Disability role which was a full-time substantive post replacing the Associate Director of Nursing role which had been formally reviewed as a stand alone post and this new role was recognised as part of the collective leadership team.

12. I worked in this role still holding the service manager role until end of March 2018 when Mr Barry Mills took up the Hospital service manager post.

13. I formally took up the role of full time Divisional Nurse in the Collective Leadership team on 01 April 2018.

**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?**

14. Patients were referred for admission to a consultant psychiatrist by their community professional and the Consultant would determine if an admission was appropriate or not.

15. Alternatively, if patients were assessed under the mental health order an approved social worker would phone requesting an admission bed. If the patient was detained a bed had to be allocated as soon as possible. If the patient required admission but was agreeable to admission and had capacity to consent, they would be admitted voluntarily however a bed usually was difficult to allocate as there was only usually pass beds available due to the ongoing requests for admission until a planned discharge took place. The acute admission wards were aware and could keep the nursing informed of planned discharge dates of the patients in their care. I think we averaged about 1.5 admissions per week.

16. Bed management was reviewed every day (and the daily statistics of admissions reported onto the HSCB monthly), so the duty nurse would liaise with the referring professional and the consultant on call if out of hours or Dr Hughes who was the aligned consultant for all adult admissions (except Six Mile Ward which was a low secure forensic admission ward under Dr Milliken's clinical leadership).

17. The nursing office would discuss potential admissions with the senior nurse manager and they looked at what alternatives had been explored such as use of community behavioural team resources or sometimes explaining that respite was not appropriate use of MAH as a treatment inpatient facility. This discussion helped inform the post admission meeting of the issues why admission was required.

18. As mentioned, bed management was a regular issue as we did not always have an available bed which then involved on occasions use of a pass bed in the admission ward or use of a bed in another ward on site until a discharge was completed on the admission ward by transferring a stable patient for an overnight or number of days. These patients who were identified and transferred into a bed in another ward were usually on the delayed discharge patient list. If they were transferred into a resettlement ward bed they occasionally remained there until their eventual discharge as there was usually always pressure to find an admission

ward bed. The number of admissions were reviewed yearly, and it was approximately same number of females to male admissions each year however there were disproportionately more male beds on site than female beds when I commenced working in MAH.

19. Factors which influenced whether a patient was admitted or not was multi factorial, such as did they have a support network at home, did they reside in a staffed community facility, were there risks to themselves or risk to others, were they known to community LD services, were they presenting with a deterioration in their mental health and community treatment of the mental illness was not working or an escalation in behaviours that were unable to be managed safely and community behaviour practitioners was not available or the treatment offered had been ineffective. Ineffective services could have been due to unavailable services, time limited services, only Monday to Friday services or 9am – 5pm only. On occasion the patient may have required admission to prescribe alternative medication and to titrate medication. However it was accepted that patients at times needed inpatient care due to acute presentations for treatment and to keep them and others safe. As stated we had about 1.5 admissions per week.

20. LD community resources and alternatives to admission options were limited especially in comparison to adult mental health services.

21. Lack of resources in the community – services were 9am – 5pm Monday to Friday in the main. There was No specific self-harm services, or no home treatment team options such as 24-hour home treatment house or 24 hour or seven-day intensive support team, limited behaviour management services, large caseloads held by community professionals, very limited number of community LD nurses. Limited number of vacancies in staffed supported housing options, limited number of respite beds or services to support carers or reduce carer fatique, and an under pressure approved social worker rota. However the HSCB was investing yearly into community resources as part of the community integration project and services continued to improve.

22. There was limited resources in the hospital which impacted on available treatments and same applied to discharge planning from the hospital wards both for adults and children. A Review of Iveagh Ward which was undertaken jointly by LD services in the Trust and HSCB in 2013 indicated different resources required, different approach and training to the treatment required for the children referred for admission there. This report outlined the challenges in the service and professional inputs and ethos required-that were needed showing a way forward. Mr Veitch, I think shared this review report with RQIA and we were subsequently inspected a couple of days later using this intelligence and the service received improvement notices to address the concerns raised which mostly concurred with the review report. This approach ultimately assisted the service in obtaining additional funding from the HSCB for additional resources and professional services on a recurrent basis to transform the delivery of the service. Iveagh childrens inpatient service transformation led to reduced patient stay, increased patient treatment options, decreased use of physical interventions and seclusion.

23. The Iveagh ward became accredited with the Quality Network for CAMHS Inpatient Services and won the chairman's ward for accountability.

24. Dr Milliken and I then advocated this approach to be developed at MAH, as substantial investment and resources were needed to deliver this - we were tasked to develop a proposal paper outlining resources and long-term vision for the hospital. In the interim and in discussion with the HSCB we were granted some non recurrent monies for an additional Psychologist as well as resources for the resettlement process on a non recurrent basis. The psychology post proved difficult to recruit to - with a psychologist moving from Iveagh to MAH and trying to replace them in Iveagh.

25. Mental Health services and LD services worked together via Co Directors Barney McNeaney and John Veitch to look at synergies which could be progressed to support patients. I was asked to work with Maurice O'Kane planning and development officer in 2015/16 to develop a way forward for the hospital – detailing the resources required. In developing the proposal for MAH I worked with Dr

Humphries, Psychiatrist, and consulted with professional leads required for a functioning funded inpatient service – pharmacy, Speech and Language Therapist (SLT), Occupational Therapist (OT), Physiotherapist, Psychology, Medical, patient advocates, GP for physical health care, Nurse Prescribing, behaviour practitioners, forensic practitioners, dietetics, social workers, and support services. A lot of these resources were not currently available or very limited for inpatient treatment – some additionalty funding had been secured temporarily as part of the resettlement programme.

26. I recall The HSCB held a workshop to discuss future provision needs, there was lot of discussion at this about community infrastructure needs which were severely lacking before investing the available limited resources into the hospital system. Community infrastructure monies were being allocated to all trusts along side the community integration project (resettlement). The HSCB however agreed that a paper should be prepared to identify the gaps in service provision in the hospital

27. There were challenges between Trusts when discharging patients from hospital to a service in another Trust location which could meet the patients assessed need. Example : Director SHSCT would decline to allow the patient not originally from the SCHCT locality to avail of primary care services such as Speech and Language Therapy. Some patients were disadvantaged by this approach and it would be raised at meetings and with the Trusts .

28. Patients admitted to hospital were reviewed by the multi disciplinary team involved with them, the MDT was limited as not all professionals required were funded and employed. Ward rounds happened weekly on admission wards and tended to consist of medical, nursing social work daycare and occasionally community professional. Families were involved through discussion with medical and nursing staff or invited to discharge planning meetings. Patient Advocates were offered to patients and invited to meetings.

29. A Carer Advocate was recruited by one of the voluntary advocacy providers following contract review undertaken by myself and introduced in and around early 2016.

30. Resettlement wards tended to have MDT reviews with nursing medical and advocates with community Trusts' care management staff attending and daycare staff if involved. Social work input was limited into the resettlement wards and was by request. Social work staffing was limited across all wards. These meetings were monthly in 2012 but increased to weekly when a dedicated consultant psychiatrist resource was identified for resettlement.

31. All patients were considered and reviewed whether they needed to be in hospital for treatment or whether they no longer required treatment. If they no longer required treatment and this was agreed by the MDT, they were declared medically fit for discharge by their RMO Consultant Psychiatrist.

32. They were then notified to HSCB, discharge could occur quickly for some patients if an existing package was already in place. If required; complex discharge planning was followed up which meant community care management professional from respective trust would attend discharge planning meetings with a community professional and an outline of their presenting needs developed.

33. If an existing service or going home was viable options these were pursued. If not, a service outline was developed and shared with the owning trust who worked with organisations and their own trusts to identify a current existing placement or develop or commission services to meet the assessed need.

34. Patients on the Priority Target List (PTL) remained on this list and occasionally were put back into active treatment as required as they were awaiting discharge but resettlement for some took years. Those who were delayed in their discharge could have become unwell, treated, and deemed medical fit for discharge a number of times.

35. Groups of individuals with similar needs would be discussed and included to make service developments plans viable and some of these individuals could be currently living in the community but their placement was at threat of breakdown. As

resettlement progressed a single consultant was identified to lead on and manage resettlement, Dr Humphries replaced Dr Milliken as RMO for the resettlement wards around 2013. Dr Milliken then concentrated more on his RMO role as Forensic Consultant Psychiatrist in Six Mile Ward and on community clinics – which also had patients requiring planned discharge.

36. Trusts tried to work together to develop plans so costs could be managed as well. All of the Trusts developed new schemes of supported living and residential care in their localities.The HSCT dowry for a resttlement patient was £85,000, some placements costed £15,000 – £25,000 whilst others £85,000 and a few £150,000 plus. We also had a couple of patients who projected costs were £500,000 per annum, due to 2:1 care 24 hours per day.

37. The HSCB gave each Trust an amount of money for discharging patients each year, unfortunately this was not enough and as the (people first) budget was utilised during the year a waiting list for funding would then be highlighted to the HSCB for additional monies as it became available. The people first budget for these discharges also had to compete with patients in the community needing placements, funding respite care and domicillary support packages. This meant that there was increasing numbers of patients who had been deemed fit for discharge but there was no suitable placement or that funding for the placement was not available. Some of those awaiting discharge could be waiting 10 years or more and included children who had been delayed in their discharge in Iveagh ward, transferred to MAH to await funding and a service in the community.

38. A monthly spreadsheet was compiled by each of the Trusts and collated and forwarded to HSCB – the monthly community integration meeting chaired by John Veitch and HSCB attendees (Linus McLaughlin, Adrian Walsh, Seamus Logan, Joanne McConville, Aidan Murray are the names I can recall – different leads at different years) all community Trust leads attended this meeting and were expected to feedback on each Trusts progress.

39. Some detained patients during assessment processes were deemed not to fall within LD criteria for detention to inpatient LD services and subsequently

discharged from detention to their community team for follow up and if a further admission was required, they accessed a mental health inpatient bed. Some patients transferred to mental health inpatient or community services, or brain injury services.

40. All patients who were deemed not in active treatment - options were actively being explored during my time as service manager with the exception if they were assessed at end of life care. A number of patients passed away in the hospital each year due to frailty and / or old age.

41. As resettlement progressed and significant number of patients left the hospital we took down beds and reduced the overall compliment of beds in the hospital. So admissions to these beds ceased which allowed for wards to decrease the numbers in their wards meaning they were less crowded and moved wards closer to closure.

42. The following wards were closed as part of the Community Integration Project which I understood released the monies for further discharges.

    Finglass ward was closed Oct 2012 – was due to close by new year but closure was brought forward due to safe staffing concerns.

    Mallow ward – this ward had already been closed and decommissioned but was reopened in 2011 due to an admission of a NT patient who needed additional space and could not be managed in the admissions ward. No funding or budget was in place for the operation of this ward. Two other patients joined him in Mallow for short period until accommodation was adapted on site in Erne Ward to support these two patients, with the third patient discharged to a planned community placement which had been sourced prior to his transfer from Iveagh ward. Mallow was then re closed. I reviewed the operation of this ward and ensured responsibility for the ward was aligned to a charge nurse for oversight of care provided.

    Rathmullan ward – this ward was expected to be the last ward to close of resettlement wards however as it was a very old building it suffered fractured water and heating pipes during the summer months around 2014 which meant there was

no heating to the ward for a number of days. Emergency heating supplies were put in place to ensure ward remain warm as a lot of the patients were frail. Senior nurse manager, B Ingram and estates personnel made representation to me regarding concerns that should this happen again in winter months it could be difficult to maintain a warm ward. In discussion with the core management team it was agreed to refurbish a wing of Greenan ward to accommodate the remaining 9 patients after others were discharged to planned placement. Relatives were notified of the concerns regarding the reported maintenance issues and planned transfer to Greenan ward once required refurbishment work was completed.

Old stone Ward – this ward was a series of semi detached shared houses and shared bungalows near the main road outside of the main hospital site integrated with general housing stock. The Trust had worked with Occupational Therapists and a housing Association to develop and achieved planning approval from Antrim Council for bespoke designed bungalows for a supported housing scheme beside the Oldstone Houses for patients who could not be managed in shared housing, residential or nursing care. This never got progressed beyond full planning permission. Oldstone Houses later re-opened in 2019/20 as a community supported living facility and not part of the hospital provision.

Greenan Ward – this ward closed when patients resettled to mainly nursing and residential care options

Moylena ward which was a villa type building closed following a fire on the main electrical board attached to the ward. Three patients were transferred to other wards. Dr Humphtries RMO for the ward and I discussed the fire with Barney McNeaney Co Director who consulted with Cecil Worthington Director who both recommended the immediate closure.

**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?**

43. Core Management Meeting were chaired by John Veitch Co-Director, and attended by me, Mairead Mitchell Governance Lead, H92, Senior Social Worker and Dr Milliken Lead Consultant Psychiatrist. Minutes taken by Grainne O'Neill, secretary. Agenda and minutes were available. Held fortnightly.

44. Senior nurse managers meetings held on Mondays by me for verbal update on hospital.

45. Sister / charge nurse Meetings – chaired by Senior Nurse Manager for wards they managed.

46. Staff meetings on individual wards chaired by ward sister or charge nurse.

47. Staff meetings social work team chaired by senior social worker.

48. Resettlement meetings held by Dr Humphries minutes taken to which patient relatives were invited.

49. Managers Meeting chaired by myself attended by Ward Sisters, charge nurses, senior nurse manager, social workers, nurse development lead. Later I included support services manager, psychology, OTs – agenda, minutes available.

50. Medical staff meeting held monthly. Minutes taken.

51. Professional Nurse meeting – agenda minutes available attended by hospital and community senior nurse managers and nurse development lead.

52. Monthly Associate Directors meeting – chaired by Brenda Creaney City Hospital agenda minutes available.

53. Three monthly Nurses in Difficulty meeting – chaired by Brenda Creaney – City Hospital agenda minutes available.

54. Cross Trust Co Directors Meetings

55. Community Integration Meetings MAH monthly initially chaired by HSCB I think then Co Director J Veitch.

56. Workforce Strategy Meetings chaired by John Veitch commenced 2012.

**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.**

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

57. The use of seclusion and physical interventions i.e. use of MAPA was produced every month by resource nurse Jenny Armstrong in governance team which was led by Mairead Mitchell. Reports sent to wards and available to senior nurse manager, ward sister / charge nurse and nursing staff. Use of MAPA was reviewed by a trainer in MAPA who was a senior nurse – all forms reviewed and clarity sought as needed on its use and circumstances of same. This review and audit role was held by Clinton Stewart, then Michael McBride and Damien Okane who were all MAPA trainers. There was joint working with the knockbracken team in relation to the recording and review processes using the Trust dating system. All wards had a trainer as part of their team, I recall visiting Killead Ward and Chloe Jade McDonald nurse MAPA trainer was talking through with her staff MAPA use that had occurred and learning from same.

58. Senior Social worker H92 prepared report on safeguarding for wards and presented safeguarding reports to core management group until safeguarding lead Michael Creaney was appointed who then presented same. They would have discussed any trends eg noted over wards or at the same time last year ie M Creaney indicated that when Xmas decorations went up too early this led to

increased patient on patient incidents noting that when for management of cleaning and infection control when decorations went up later incidents were fewer.

59. Complaints were presented at monthly LD service management meeting chaired by John Veitch Co-Director at Mater Hospital and three-monthly governance meeting at Mater Hospital chaired by Mairead Mitchell Governance lead. These complaints covered hospital and community issues.

60. I don't recall the use of PRN medication being regularly reported in MAH, but think a medical audit was carried out but unsure of year. PRN medication trended to be oral medications. Rapid tranquillisation using IM injections was not a feature of the treatment prescribed.

61. As the seclusion reports focused on MAH PICU ward and Iveagh senior nurse manager Barry Mills and Rhonda Scott and Michael McBride would discuss variations and activity to core management team and actions being undertaken to manage and reduce same. These reports were also presented and discussed at medical staff meeting monthly.

62. Accident reports and incident reports produced at same time with similar approach – if related to a particular patient on first admission and how any treatment offered was reducing same or no improvement.

63. If a patient was aggressive to other patients how this was being managed was discussed regularly with me by senior nurse managers and safeguarding lead and discussion about alternatives such as increased activities, additional staffing, 1:1 or 2 :1 or alternative environmental changes. There was discussion if bids for monies were required to support environmental changes to reduce their occurrence or severity. The majority of safeguarding incidents on site were patient on patient incidents. When solutions were considered for safeguarding protection plans to reduce patient on patient incidences – this often led to increased incidences of assaults on staff by patients. For those patients that presented with frequent serious incidents against staff we considered bespoke packages within the hospital, these were individual designed spaces that reduced the occurrences

of aggression, but they also allowed us to explore what type of social care package would work and be viable for the patient in the community and provide realistic costings of same to the HSCB and owning Trust.

64. An example of environmental changes undertaken was the physical separation of the male and female admission wards by putting up new interior walls to reduce the incidents between male and female patients. At design stage the male and female wards were open plan design and patients could move freely between the two spaces.

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

65. Community integration project – individual families were regularly invited to discharge planning and resettlement meetings. Parents and friends of MAH were on project board of community integration project which was leading on resettlement and closure of long stay wards.
66. Families and parents were involved in the design of the new hospital when commissioned.

67. Patient Advocates trained and supported through ARC – Tilli group, patients were selected to join the group however on occasion B Mills would inform me there was discussion through ward teams and RMO if they felt patient was unwell at present to participate.

68. Commissioned Patient advocates held meetings on wards.

69. Development of a carer advocate post by myself with voluntary provider.

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

70. Joint hospital and community LD yearly meeting to agree priorities and work plan for incoming year of what achieved and what still to do. This included reviewing how the community integration monies would develop community resources and how in turn that would impact on the hospital. This was followed up with yearly appraisal with Co-Director with agreed targets and work plan.

71. Monthly meetings as LD service managers to update on work plans and targets Performance targets set by HSCB and Department of Health.

72. Working with care managers and community professionals and other Trusts on specifications for new services and specific individuals for new services alongside ward sisters and social workers to ensure new services met assessed needs.

73. Working with contracts department and planning development manager and specialist OTs and community professionals to agree specifications for services to attract service providers and HSCB on cost per place.

74. Working with community teams, care management and service providers on new service developments and when patients moved into schemes to support placements.

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

75. In the ward operational policies the Community team professional was to stay involved with the patient after admission for information on factors leading up to admission and plan for discharge.

76. The community professional was to attend first MDT ward round following admission. The Community professional was to be invited to all meetings and discharge planning processes.

77. Care management referral was to be processed by the ward for complex discharge planning or commissioning of services where care management services were not already involved.

78. All patients were to be offered patient advocate services on admission with information leaflets to be given and information displayed on the ward in relation to advocacy services. All trusts had their own aligned patient advocacy services and contract with their closen provider. The hospital only held the contract for Belfast patients and the carer advocate which was for any inpatient.

79. Carers to be informed of carer advocate service (after set up). This service was only for carer of inpatients not community patients.

80. Carers informed of planned Parents and Friends Meetings and posters displayed of same prominently on wards. Families and patients asked on admission if they wished to avail of advocacy.

81. A Social worker was aligned to all core wards but resettlement wards were assigned social worker input upon request due to capacity issues.

82. AHP services involvement was based on referral by MDT and linked to referral acceptance.

83. Dental services were offered on admission, a dental suite was available in daycare building for this purpose - my understanding this was to ensure that dental pain was not a factor in the admission.

84. Primary nurse allocated to ensure assessment of needs completed and agreed with team. This role was also to Co ordinate communication between professionals and the patient and their family.

85. Development of resettlement team in each Trust was in place to assist and lead on discharge planning for patients requiring discharge, resettlement and on the PTL list and delayed discharge list.

86. A dedicated Psychiatrist employed for resettlement who chaired weekly resettlement meetings with MD team members and family members to discuss, plan and take forward discharge plans. A community integration manager was in place on a temporary basis Co ordinating and liaising between ward team, psychiatrist, nursing team, resettlement team, and community professionals and service providers.

87. Minutes were maintained of individual patient meetings relating to resettlement and notes of input or otherwise from families.

88. Patient advocate undertaking baseline betterment questionnaires for patients being discharged from PTL list, liaising with patient and family. Follow up questionnaire 6 weeks after discharge, 6 months and at one year. I think a report was available on prelimary findings of the betterment questionnaire.

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

89. Induction processes for new staff were developed and led by the Nurse Development Lead (NDL) once appointed.

90. The Trust roll out of corporate welcome for all new staff (and staff taking up new posts) was in place which highlighted policies and how to access them on the intranet.

91. Staff were made aware on commencing employment of how to access intranet.

92. Mandatory training schedules were in place on the wards and a training matrix overseen by the ward sister and checked by the senior nurse managers.Training records were held by wards and I think it was 2013 when some admin support was allocated to ward sisters to assist in this recording via central nursing. Admin support on site was limited.

93. Training was booked by staff and monitored by ward sisters, NDL and senior nurse managers. Reports were submitted to HR working group regarding mandatory training.Reports were provided to me by NDL and central nursing on supervision and appraisals .

94. Policies and procedures were put online - these were monitored by resource nurse in governance team for review and updating. New policies were signed off at Trust Governance Meeting, whilst some policy updates or over arching guidance were signed off at Directorate Level I recall.

95. New policies were highlighted by the Resource nurse in governance team to wards and departments and staff sign off on updated policies after reading was overseen by ward sister / charge nurse or department lead.

96. IIP investors in people accreditation was being pursued by the Trust which was checking out staff knowledge base and views on being part of Belfast Trust and how we demonstrated knowledge of value base, policies and procedures. I think this was achieved – feedback was available for each area indicating compliance with same and achieved by using a random selection of staff to be interviewed.

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

97. Clinical supervision was in place for qualified nursing staff through individual and group sessions and this was reported on quarterly via the wards to the NDL. This was to meet the requirements for two sessions per year. Healthcare assistants are supervised by nursing staff on a daily basis as tasks allocated on wards by nurse in charge.

98. Reflective practice and supervision of behaviour nurses was provided and led by a psychologist, though still offered clinical nurse supervision twice yearly.

99. Social workers had formal supervision monthly by senior Social Worker.

100. Senior social worker supervised monthly by service manager and clinical supervision three monthly with tripartite with service manager and professional line once per year.

101. Allied Health Professionals and medical staff were managed and supervised through own professional line structures.

102. As Service Manager I attended regular management supervision with Co Director. Clinical supervision was on a peer to peer basis with an Associate Director of Nursing or Co Director of Nursing.

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

103. Senior Nurse Managers MAH management supervision monthly by myself with yearly appraisal and goals set for incoming year.

104. Senior Nurse Managers hospital and community had clinical supervision twice per year with me as Associate Director for nursing.

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

105. Core Mandatory training matrix was in place for all staff to achieve. This was developed alongside central nursing, HR and Management.

106. Senior nurse managers professional development was discussed at supervision and all these managers were encouraged to participate in the living leadership programme through the Beeches management centre as none of the senior nurses had attended this prior to when I took up post.

107. Nursing staff training was facilitated through the nurse education budget and a number of courses were commissioned yearly for ongoing professional development. This included courses which needed developed supported by NDL.

108. Alongside this was Beeches Clinical Education Centre courses which staff applied to through their ward sister.

109. Belfast Trust annual staff development day for heads of services and senior staff, and each service area had a staff development day each year to explore service achievements and goals.

110. Healthcare assistants had access to courses through the clinical education centre, mandatory training, and access to employment-based pre-registration nurse training. NVQs and equivalents were available for healthcare assistants.

111. Nurse attendance at corporate nursing events, IIP training, service improvement training was available. Conferences relating to the area of practice were available and learning disability network forum days developed as part of the Review of Learning Disability Nursing and open to all registrants – the forum was supported by NiPEC.

112. I was involved in Commissioning of new courses through corporate nursing education commissioning such as specialist practice courses, developing professional practice, nurse prescribing. I set up a number of meetings with the nurse leads in other Trusts and this involved agreeing to send half of the required cohort from MAH to ensure courses actually ran as nursing numbers in other Trusts were small in number. Community LD Nurse course supported which was delivered by Owen Barr at University of Ulster, this course was going to be decommissioned as staff had not availed of it, but our group of Trust nurse leads supported its delivery to allow it to remain a viable option for future years.

113. Nurse Prescribing course commissioned and additional training post qualification for nurse, training requested but allocation of places depended on number of staff who applied across the Trust as opposed to service area, so while courses were requested, we had to wait for approval to attend.

114. Working with nursing colleagues in other Trust areas to develop exchange opportunities for nursing staff, in childrens nursing, mental health to develop mental health assessment skills.

115. As part of the review of the hospital and its delivery plan for acute treatment specialist practice courses were commissioned to plan for the development of specialist roles required and the implementation of a model similar to Iveagh wards transformation.

116. Opportunities were also available for inclusion in service improvement projects which had training as part of the process and team development.

**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.**

117. Yes, I reviewed nurse staffing on MAH site, placing nurse staffing on the at risk register in March 2012. I was informed on taking up post that a moratorium had been put on recruitment in 2010 /11 as there were wards closing on site and that surplus staff would require to be redeployed as part of the resettlement programme.

118. Recruitment drives were undertaken regularly throughout the year in response to filling vacancies but all posts offered in 2012 were of a temporary nature at band 3 and band 5, 6 and 7. This changed to permanent posts for band 5 staff around late 2013

119. A Band 8a senior nurse manager post was removed by Co Director for efficiency savings around time I took up post in early 2012.

120. I reported on staffing levels / concerns and issues at monthly corporate nursing meetings and at three monthly at corporate nursing workforce meetings with the

Director of Nursing and attended by HR, Staffside organisations and Trust finance department and other Associate Directors of Nursing.

121. Three monthly workforce strategy meetings at Muckamore commenced 2012 chaired by John Veitch and attended by senior staff from adjoining Trusts, Staffside, other Trusts HR representatives, managers from various departments in Muckamore (estates, hotel support services, AHPs, admin and this also included the admin staff for the Regional Emergency Social Work Service. Neil McDaid HR organisational development was a core member of the strategy team with Joan Peden HR.

122. I and the senior nurse managers worked with Margaret Devlin in corporate nursing to review staffing levels for nursing using Telford model for the wards. I attended training with Margaret Devlin on staffing levels assessment. Recruitment drives were undertaken to employ additional permanent Band 5 nurses and temporary Band 3 healthcare workers. Brenda Creaney authorised the employment of permanent Band 5 nurses to any vacant post in 2013 as there was a low number of qualified nurses qualifying yearly, and the movement of nurses between Trusts, departments and retirements.

123. Over Recruitment of Band 5 staff on a permenant basis was introduced but as only a set number was trained each year by QUB. This was to employ more staff than was currently funded in our core budget to assist with specialising of patients. We were successful in attracting the majority of newly qualified staff each year from the cohort at QUB as well as on occasion staff from universities in Scotland and Liverpool. We explored employing nursing staff in other fields of nursing - i.e. mental health nursing, children's nursing. This approach was already in place in acquired brain injury services, Camhs, health visiting who advertised for LD nursing applicants – nursing across all fields of practice were experiencing shortage of registrants with increases in nurse training required.

124. I worked with Neil McDaid HR organisational development team in relation to the Monitoring of numbers of nurses and healthcare assistants approaching retirement age at 55 as staff working in mental health and learning disability

services had mental health officer status if employed pre 1995 which allowed up to full pension entitlement on retirement at age 55 was in place.

125. I worked with the workforce leads Margaret Devlin and Aisling Phelan. to increase numbers of available bank staff for the hospital which included Facilitating and Encouraging staff who were due to retire to consider returning as part time bank staff, or in part time substantive posts. The senior nurse managers worked with Colm Quinn each week regarding bank usage and cover.

126. Agency staff use was not a regular feature as there was very limited pool of LD Nursing staff, the nurse bank was regularly asked to secure agency staff if possible. I also added to the risk register concerns about some staff working excessive hours which required monitoring by the senior nurse managers. Staff can opt of out the maximum hours of a 48 hour week by signing a waiver which lots of staff across Trusts do. Monitoring of excessive hours was about ensuring staff were not working 7 days a week on long days or night duties, and senior nurse managers being proactive and encouraging staff to take their rest day each week and having 6 days as a maximum and not as a regular work pattern.

127. Later on, when required for the site later in 2017 due to the number of suspensions I worked with Colm Quinn / and M Devlin I think: to get a block booking which was facilitated through the nurse bank – the agency was required to provide registrants in line with the minimum standards of core training set by the Trust for agency usage. The agencies who were able to commit to the block booking were from England and english nurses trained in mental health with extensive inpatient experience though mainly in mental health services. However, lots of mental health inpatient services in England were used for patients with a learning disability for admissions. I also worked with the bank and agency to Co ordinate training such as additional and timely MAPA training as part of their induction to the Belfast Trust. I worked with the Trusts MAPA trainers based in knockbracken healthcare Park to run specific courses for this.

128. Reviews of LD Nursing took place with leads from each trust and the department of health at various stages. Through representation and replies from

myself about the need for more registrants and other Trust leads - nurse training places were not decreased but maintained, and increases considered. Services being developed were very much social care models but I submitted views that specialists would be required in behavioural management, forensics, acute home treatment as well as meeting the growth of community nursing services and replacing nurses who were retiring.

129. In undertaking the development of the way forward for the hospital and reviews of Telford based on increased patient acuity our workforce paper indicated a significant increase in the number of registrants required to deliver the inpatient service.

130. There was a Paper developed for LD nursing by department Strengthening the Commitment was released April 2012 with a number of us involved in the development of an action plan and its roll out. The action plan had targets in each nation of the UK for RNLD.

131. This involved Participating in audits of LD nursing population in Northern Ireland (NI), their work environments and cross referencing with NMC register. There was always a discrepancy as some nurses are dual or triple registered such as RGN, LDN and HV or Childrens nurse and LD Nurse. The audits helped inform nursing numbers needed going forward and discussions around having a specific OU employement based RLDN route. This I think became a reality in 2020. Up to this date if a healthcare assistant wanted to complete the OU employment based route into nursing they had to train as a mental health or adult nurse.

132. I was also part of the working group on delegation framework for nursing and midwifery services October 2016 which was revised 2017.

133. Normative staffing was being rolled out in NI, to develop safer nurse to bed ratio unfortunately LD nursing was not in the early traunches and even in 2017 I was advocating to get us added to the rollout, training was provided to ward sisters, deputy ward sisters nurse managers on normative staffing supported by Moira Mannion and her team in 2017 and 2018. Briege Quinn PHA attended one of the

sessions and Owen Barr was invited to same but unsure of attendance. The assessments indicated raising the nurse to bed ratio to 70 /30 for the core wards and 80/20 I think for PICU.

134. I worked with Aisling Phelan workforce lead in corporate nursing to develop a workforce plan for nursing for each ward directly with charge nurse sisters' deputies, senior nurse managers based on patients' level of acuity and needs.

135. Plan submitted to meeting with Brenda Creaney and Moria Mannion. Same plan required additional training and recruitment of Band 5 nursing staff and specialist practice nurses for the hospital. This linked into the proposal developed in 2015/16 and revised in 2017 regarding development of a comprehensive inpatient treatment MDT increasing the number of specialists nurses required and commissioning the specialist practice courses in advance of getting the funding as it requires two years to complete the training.

136. I Started in 2015 working with Maurice O'Kane planning department under remit from Barney McNeaney mental health and John Veitch LD Co-Directors on draft proposal on a way forward for the hospital, with a reduction in bed capacity from 85 core treatment beds down to I think less than 40.

137. This paper looked at the nursing medical AHP social work and specialist services (pharmacy, psychology GP sessions dental etc.) needed for an acute LD hospital going forward.

138. This was being progressed and costs developed to be a leading treatment facility with the appropriate skill set to deliver the right care at the right time recognising that even with community infrastructure enhancement and development an admission for some patients with a learning disability and deteriorating mental ill health may still be required.

139. In relation to the Community Integration Project (resettlement) the workforce strategy group met three monthly, agreed a work plan, and each group of staff would be reviewed as to recruitment needs, redeployment needs etc. Barry Mills

worked with staffside and a number of sister / charge nurses to agree number of staff needed on core wards. Another senior nurse manager worked with staff who needed to be redeployed to core wards from resettlement wards as they closed.

140. Information sessions for all staff were held three monthly supported by Staffside representatives, led by me and Neil McDaid HR organisational development department. This sessions also updated staff on resettlement progress.

141. Sessions were held morning afternoon and evening and typically attended by over 300 + individuals over the day with representative from every area on site. A PowerPoint presentation was delivered, and a question-and-answer session ensued on each occasion.

142. Band 5 nurses were never redeployed, we had agreement to make all Band 5 nurses permanent in 2013 and I was aware that we always continued to have Band 5 vacancies within the hospital. As staff were employed the senior nurses managers would meet before planned induction dates and agree which wards registrants and healthcare assistants were aligned to so there was equity across the wards. The Trust introduced three monthly rolling start dates with structured induction when new starts could join the organisation and our new starts attended this corporate Induction.

143. Only one Band 7 charge nurse was redeployed to a permanent Band 7 vacancy in supported housing in the community, this occurred after a ward closure when no permanent charge nurse vacancy was available on site.

144. Some redeployment of Band 3 healthcare workers for the site continued throughout my tenure in Muckamore to reduce the number employed on a permanent basis as seven wards were eventually closed. Following three monthly reviews at the workforce strategy we took the necessary steps to offer current temporary Band 3 healthcare workers permanent contracts when they had been with the Belfast Trust for 4 years as part of contract renewals and employment law.

145. As the healthcare workers were band 3 staff they all had to have a minimum of two years paid caring experience before they could apply for a post in MAH. Previously MAH had two tier posts with nursing assistant posts at band 2 and healthcare workers at band 3 however following banding appeals undertaken pre 2012 all band 2 staff were awarded band 3 pay awards based on the duties expected on the wards in MAH. Therefore all new staff had to have previous paid caring experience to apply for a post within the hospital. There was numerous applications for this band of post at all recruitment drives.

146. Through supervision team meetings, staff meetings, concerns about staffing shortages due to illness, retirements and recruitment to new posts as part of building the community infrastructure were highlighted and raised at management meetings, core Managemnt meetings, corporate nursing and workforce meetings.

147. Action plans in relation to concerns were discussed at the workforce strategy meetings and plans adjusted to reflect ongoing changes on the site. This included admin staff, estates, PC support services etc.

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

148. MAH managers regularly reviewed staffing trends, retirement profiles, other recruitment drives which impacted on current resources.

149. An example of this was nurse recruitment to Health Visitor training programme – this was offered regionally and supported by all directors of nursing to address regional shortfall in health visitor staffing levels. All wards in the Belfast Trust through their associate director of nursing including myself reported nurses applying to same and being successful. MAH seconded staff in each round of training opportunities funding same. I proposed not supporting the secondment and this was temporarily agreed by the Director of Nursing however the staff opted to give up their permanent job to undertake the training on a temporary contract regardless. This I believe was due to the knowledge that everyone was fully aware

that vacancies were available if required due to the inadequate number of newly qualified nurses being trained against the needs of the existing services.

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

150. A Seclusion room operated in ICU ward with a dedicated room with an adjoining toilet which was developed and designed when the new core hospital was built in 2005 I think.

151. A seclusion room was also built into the design of the new Iveagh children's ward.

152. Seclusion was a last resort action and if required to keep a patient and others safe and there is potential for harm to others if no action was taken. It was to be in place for the shortest time safely. A policy was in place.

153. From my recall If required a nurse would ring the ward doctor or out of hours doctor to gain authorisation for seclusion, a seclusion care plan would be commenced, and the patient observed in seclusion by an allocated member of the team until they were settled enough to come out of same. Observations had to be recorded on a seclusion care plan every 15 minutes. The seclusion care plan was uploaded onto the Paris system when it was introduced.

154. If in seclusion for a longer period they were reviewed by duty nursing officer or senior nurse. If seclusion continued, they were reviewed medically as well

155. From recall the length of time in seclusion was usually about 20 minutes in reports presented to core management group.

156. At the patients MDT meeting the use of the patients seclusion was reviewed and trends noted for the patient to reduce its use. Ward sister / charge nurses would discuss a patients use or trend with Barry Mills as senior nurse manager (or Iveagh Senior Nurse Manager). Barry Mills would attend core management group

to discuss trends on seclusion / restraint usage. It was noted at core management group of the reduction in use of seclusion in Iveagh as a result of the service improvements, development of PBS approach and further investment in core members of the professional MDT in Iveagh. There was discussions ongoing about how to achieve this in MAH.

157. In supervision and meetings with the other senior nurses we discussed increasing the registrant nurse to bed ratio in ICU to see if this reduced incidences. The bed to patient ratio was increased in PICU, and a service improvement project undertaken in this ward in 2016 / 17.

**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.**

158. As service manager I was aware of a number of occasions when an allegation of abuse of a patient by a staff member. On each and every occasion of alleged abuse that I was made aware of an immediate safeguarding protection plan was put in place. The protection plan was then discussed with and agreed with the designated officer and adjusted if required or not adequate taking advice as needed. Where an allegation was made against staff the Trust from where the patient was admitted was notified and they would be the lead designated officer. A disciplinary investigation would be undertaken and where the disciplinary investigation recommended a disciplinary hearing - this would be held asa practicable resulting in different range of sanctions or outcomes for the staff member involved as per the disciplinary policy if allegation upheld

159. I was notified on my first day of work in post of an alleged assault on a patient by a healthcare worker. He was sent home from the ward as an immediate protection plan and later John Veitch, Co-Director, issued a suspension order to the worker. The staff member was issued with a formal caution by PSNI on the day of the court hearing before he went to trial when he accepted that he was guilty of the offence and accepted the adult caution. At a subsequent disciplinary panel

he was dismissed after formal support and representation by his Staffside organisation. He appealed the dismissal, but this was upheld at appeal.

160. I commissioned a number of disciplinary investigations following allegations of abuse. Some of the allegations were not upheld, and some were able to find supporting evidence of abuse following which they were followed up with disciplinary action in line with the Trusts policy on same.

161. I recall a staff nurse was dismissed at disciplinary hearing for slapping an elderly patient's hand – this was reported immediately by MAH ward staff. She was reinstated on appeal with a final warning.

162. A healthcare worker was reported by MAH ward staff for squiring water on a patient's trousers and laughing at him as it would have appeared he had been incontinent; this was followed up by PSNI with an adult caution I think and action within the Trust of a formal disciplinary hearing and warning issued.

163. A healthcare worker deliberately pushed a patient causing him to fall – outcome of the hearing was dismissal, and the dismissal was upheld on appeal. This charge was dismissed in court.

164. Investigation and disciplinary action taken against ward sister for delay in reporting a safeguarding concern.

165. Healthcare assistant allegedly manhandled a patient - investigation recommended disciplinary action, however staff member withdrew statement and declined to give evidence after the case was dismissed at court hearing and the reporting staff member were viewed as an unreliable witness at the court.

166. Investigation commissioned and disciplinary hearing and sanction given on verbal abuse towards a patient by a staff member.

167. Investigation commissioned and disciplinary hearing taken on inappropriate management of a patient by a staff nurse placing another staff member at direct risk of harm.

168. Nursing staff subject to disciplinary hearings would be notified by myself to Nurses in Difficulty Meeting with Brenda Creaney Director of Nursing – Registrants were referred onto NMC for conduct hearings as necessary. Staff would also be referred onto the vetting and barring service.

169. Staff subject to suspension or restrictions on duties would be notified to the nurse bank as well to ensure they did not work else where in Trust until investigation and processes completed. Staff would also be asked if they worked elsewhere in a care capacity.

170. HR was notified of all allegations and outcomes of investigations and assisted me in terms of reference for investigations, outcome letters, and disciplinary outcomes to ensure compliance with employment law. Corporate nursing governance lead assisted me with notifications to NMC.

171. I was also informed of the incident on the CCTV in relation to the August 2017 safeguarding concerns and suspended the staff member immediately pending investigation. PSNI notified of incident on day reported by charge nurse.

172. I was then informed by Brendan Ingram business manager and Barry Mills a couple of days later of the possible availability of a CCTV recording. Brendan Ingram indicated that a systems check had been carried out and how it might show the incident. He advised me as governance team to speak with Trust solicitor to see if we could retrieve and use it. He contacted me 5.30pm in and around 20th September to inform me he had viewed the incident on the CCTV. The next morning he accompanied me to view same and showed me the incidents on the CCTV which he had viewed on the system. I reported the video evidence to Brenda Creaney, Cecil Worthington, by telephone and Marie Heaney directly after viewing the incidents. Brendan Ingram downloaded a copy of the footage which was later given to PSNI officer.

173. Incident of 01 October 2017 when patient in Six Mile Ward accused night staff nurse of assault – I viewed the CCTV with safeguarding officer, the staff member suspended from duty and referral made to nurses in difficulty and later a referral to NMC.

**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?**

**174.** In relation to CCTV this was discussed at core management meetings and action agreed to cost it and submit business case to install it in core wards. This Capitol bid case was submitted, for 5 wards based on available funding. B Ingram was the directorate lead on the committee for Capitol expenditure and the case was approved. I recall work had to commence before end of March 2015 to retain the approved monies. Brendan Ingram and Barry Mills were delegated to develop the CCTV policy and carry out necessary consultations for example with the staff side organisations, before we could operationise the system. I was not in post for a period of months around this time from March returning some time in July 2015 due to urgent major surgery. I was not aware when the project was completed due to my absence from the workplace.

**175.** B Mills and B Ingram did circulate the policy for comments. I recall human rights considerations being raised by another Service Manager in 2016. It finally passed in June 2017 and I discussed a communication strategy as per policy with Brendan Ingram when he informed me the policy had approval. B Ingram and estates were sourcing signage to notify staff and patients and families of its usage at this time. The system was to go live after the communication rollout and a date agreed for early September. I informed that the system was recording late August 2017 when B Ingram notified me of the possible footage following the reported safeguarding allegation. On his advice I sought advice form DLS notifying the Co Director of this, on whether we could access the footage, DLSc confirmed we should proceed. B Ingram advised me he had to get the company to assist him which he did. He notified me of his access in and around 20th September. The original staff member

had already been placed on precautionary suspension and protection plan in place, further staff were placed on precautionary suspension as a result of viewing the footage

176. Example Two resettlement wards in MAH leased cars. Yearly finance audit indicated payment for use of the Ward car on trips were not being evenly allocated to the patients personal accounts. This resulted in some patients receiving refunds to their accounts.

177. Example of costly service for patients. Using the Ward car which two specific wards had in place was expensive for patients ie going into Antrim in a taxi could cost approx £5 or £10 return. However the Ward car was booked out on a morning or afternoon session at £45. This cost was reasonable if the trip was driving longer distances or going places other than Antrim town, however a lot of the trips were local. Both of these wards were earmarked for 2012 closure so the car leases were not renewed, but alternative transport options provided through negotiation with estates and policy updated as well as patients using taxis which allowed for exposure to this prior to moving to the community.

178. I discontinued the approach of staff applying for patient own funds to purchase bespoke seating – this was changed to the hospital funding this seating following an OT postural seating assessment.

179. I would like to raise the issue of the physical health care of patients on MAH site which the core management team tried to address.

180. On taking up post I was aware that the hospital had access to a local GP contract for out of hours urgent healthcare. This was delivered part of the time by a local GP practice but was also subcontracted to a medical member of MAH psychiatrist medical team who undertook around 50% of the duties. Brendan Ingram business and governance manager and I were tasked to review this contract which was undertaken and notice of termination of contract given. The contract was replaced with GPs on a roster from the GP out of hours service Beldoc

– Dr Paul Conn worked with Brendan Ingram and me to get this established for urgent of of hours care. Daytime GP cover was still not in place.

181. Physical health care of patients was overseen by psychiatrists on the site and unlike improvements made in mental health inpatient services the wards did not have access to GP services bar the urgent out of hours provision as referred to above. I attended meetings with PHA Molly Kane and Briege Quinn regarding physical health monitoring of patients with a LD with other Trusts and raised this gap in service provision and the detrimental impact on patients who lost their access to GP services once admitted to a hospital. Dr Joan McGuinness SHSCT confirmed at the meeting that her inpatient services had a similar deficit in service. Molly Kane requested a paper proposal regarding same which I and Dr Humphries developed and submitted to Briege Quinn PHA. Dr Milliken I understood also raised this gap in patient care with Dr S Bergin. Unfortunately no further progress was made on this matter at my time of leaving MAH.

**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.