Muckamore Abbey Hospital Inquiry

Organisational Module 9 – Trust Board

WITNESS STATEMENT OF BRENDA CREANEY

I, Brenda Creaney, Executive Director of Nursing and User Experience within the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 13 March 2024. The statement addresses three different sets of questions posed to me relating to:

    a. the Trust Board of the Belfast Trust (the Trust Board);
    b. the 2018 “Way to Go” Report; and
    c. my role as Director of Nursing and User Experience within the Belfast Trust.

2. This is my second witness statement to the MAH Inquiry. I have already provided the MAHI Inquiry with an extensive witness statement on behalf of the Belfast Trust relating to Module 6b: the Ennis Ward Adult Safeguarding Report. I also assisted with the MAH Inquiry Evidence Module 4 Belfast Trust witness statement relating to staffing.

3. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked “BC2”.

4. The 13 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found at Tab 1 in the exhibit bundle.

Qualification, Experience and Position of the Statement Maker

5. I have been the Executive Director of Nursing and User Experience in the Belfast Trust since January 2010. I have responsibility for two extensive portfolios. The first is in respect of Nursing, Midwifery and Allied Health Professionals. The second is for Patient and Client Support Services. As an Executive Director I am a member of the Executive Team and the Trust Board.

6. I commenced my professional career as a Registered Nurse in March 1988.

Questions for Trust Board Members

Question 1

Please identify:

i. The time period in which you were a member of the Trust Board.

ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub committee(s).

The time period during which I was a member of Trust Board

7. I have been a member of Trust Board since my appointment as Executive Director of Nursing in January 2010 and continue to be a member at the date of making this statement.

The sub-committees of Trust Board of which I was a member

8. The sub-committee structure of the Belfast Trust has changed during the time I have been on the Trust Board. The sub-committee structure is set out in the Assurance Framework. Certain sub-committees themselves have other committees or steering groups that feed into their work. Although not all of the committees I am about to mention are direct sub-committees of the Trust Board, they all feed into the Trust Board's work and ultimately feed into the Trust Board as part of the Assurance Framework.

9. I attend meetings of the Assurance Committee, and am a member of the Charitable funds advisory committee and the Safety and Quality Steering Group. I am a

member of the Belfast Trust Executive Team. In addition, I chair the Infection Prevention and Control and Antimicrobial Improvement Team, which reports to the Safety and Quality Steering Group (now known as the Clinical and Social Care Governance Group). I am also a member of the Service User Experience Group.

The composition and remit of each of the sub committees of Trust Board of which I was a member

10. The Assurance Committee is a standing committee of the Trust Board. At present, its members are the Chair and the Non-Executive Directors of the Belfast Trust. Executive Directors of the Trust Board are in attendance at these meetings. The Assurance Committee's remit relates to providing oversight of the corporate governance and assurance arrangements in place throughout the Belfast Trust.

11. The Charitable Funds advisory committee is comprised of a number of both Executive and Non-Executive Directors of the Belfast Trust. Its purpose is to oversee the Belfast Trust's charitable funds and to ensure that monies held as part of charitable trusts are managed appropriately.

12. The Executive Team comprises the executive members of the Trust Board. Its remit is concerned with ensuring that governance and service improvement is applied throughout the Belfast Trust. The Executive Team meets weekly. Its functions include ensuring that the Trust Board is appraised of progress or other issues affecting performance within the Trust.

13. The Service User Experience Feedback Group is a committee that feeds into the Assurance Committee. Its remit relates to overseeing complaints and compliments made by service users, service user feedback, SAIs and other related matters. A number of sub-committees feed into this Committee's work.

Question 2

Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those

structures and processes in ensuring adequate oversight of MAH at Trust Board level?

14. The Trust Board is comprised of the Executive and Non-Executive Directors of the Belfast Trust. Its purpose, as described in the annual Assurance Frameworks, is to provide high quality care, which is safe for patients, service users, young people, visitors and staff. It endeavours to perform that duty through its governance structures and accountability mechanisms. It receives assurance from the Directors of the various directorates within the Belfast Trust. Given the size and scale of the Belfast Trust, it is not possible for the Trust Board to individually monitor or assess specific service areas unless there is a reason to do so. In order to oversee and monitor performance across the entire remit of the Belfast Trust, governance structures have been put in place at various levels throughout the organisation to ensure assurance is provided through to the Trust Board by the operational Directors of the Belfast Trust.

15. As set out in the Assurance Frameworks, the principal responsibility for individual services resides with the Director of the directorate within which the relevant service is situated. Each directorate has its own governance structure and risk management mechanisms. Where some issue arises that requires oversight at a higher level, the issue within the service can be escalated to the Trust Board by the relevant Director. An example of this happening occurred over Muckamore Abbey Hospital (MAH), when the relevant Director escalated the emerging problem to Trust Board in the Autumn of 2017. These same arrangements apply across the Belfast Trust, including for all its hospitals.

16. Muckamore Abbey Hospital (MAH) initially resided within the directorate of Mental Health and Learning Disability at the time of my initial appointment in 2010. This service had a Director who was a member of the Trust Board. Over time this structure has changed. Subsequently, Mental Health and Learning Disability services formed part of the Directorate of Adult Social and Primary Care. The primary responsibility for MAH therefore resided with the Director of that Directorate, who is a member of the Trust Board.

17. The reporting arrangements for MAH were revised in 2019, with different directors taking on different areas of responsibility connected to MAH because of the level of the ongoing problems. I dealt with the regulatory processes that arose from the investigation. Also in 2019 the roles of the senior nurse advisors were developed to take into account the scale of the investigation that was being conducted under the joint protocol. Two senior nurses were appointed to undertake these roles and have developed expertise in the various processes, working in close collaboration with MAH senior team, Human Resources, RQIA, the PSNI and the Department of Health.

My view of how effective those structures and processes were in ensuring adequate oversight of MAH at Trust Board level

18. In my view the structures in place had the capability to provide adequate oversight at Trust Board level. The director for the service could always report to Trust Board, or any relevant committee of Trust Board, any issues they considered they needed to. However the operational business was managed within the directorate at the direction of the service director. Following the matters that arose in the Autumn of 2017, a monthly safety report on MAH came to Trust Board, and a weekly report came to Executive Team.

19. The Associate Director of Nursing, subsequently the Divisional Nurse, reported to the director of the service and to me as her professional lead. The post holders attended my monthly Senior Nursing and Midwifery team meetings (SNMT) where they reported on a range of issues. The content of the meetings changed over time; I attach a representative sample of meeting minutes behind Tab 2 of the exhibit bundle that demonstrate the issues that arose during these meetings. They also attended the bi-monthly work force and fitness to practice meetings which I chaired. Following the matters that occurred in Autum of 2017, and once the scale of the issues became clearer, I also commenced a separate meeting where the specific regulatory issues could be discussed confidentially and action plans addressed. This meeting was attended by the Divisional Nurse, the service Director, adult safeguarding, a representative from Human Resources, and my central nursing team.

20. There were therefore a range of structures throughout the Belfast Trust that were intended to provide oversight of MAH. Before I became aware of safeguarding concerns at MAH in September 2017, I had no reason to believe that those structures were operating anything other than effectively. Once I became aware of the concerns, it is my view these structures were effective and responsive to the very difficult and evolving situation at MAH.

Question 3

To your recollection, how often was MAH included on the agenda of:
i. Meetings of the Trust Board.
ii. Meetings of the Executive Team.

21. As I have described above, the principal responsibility for any individual service is the Directorate in which that service is located. A service such as an individual hospital or ward would not ordinarily appear on the agenda either of the Trust Board or the Executive Team unless there was a specific reason relating to that service that required the Trust Board's attention. The Trust Board is largely concerned with strategic matters that are relevant to the entire Belfast Trust. The only time MAH would have appeared on the agenda of either meeting would have been when there was some concern or issue pertaining to MAH that had been specifically raised to Trust Board or Executive Team level. This would be done on an *ad hoc* basis depending on what issues arose.

22. From looking back at minutes of Trust Board I can see that MAH was included in the agenda of Trust Board and the Executive Team prior to 2017 when the director needed to report an issue. For example, the PPS decision around two staff from the MAH Ennis ward came to a confidential Trust Board in April 2013, brought by the then director. However, there were not regular reports until Autumn 2017, when MAH became a standing item both at Trust Board and at the Executive Team. This is the same as how any other service area within the Belfast Trust would be treated. Matters were escalated within the devolved accountability arrangements for all directors and directorates.

23. The PICU (MAH) incident that occurred in August 2017 was brought to the attention of the Director responsible for MAH, Marie Heaney, in September 2017. Ms Heaney discussed this incident at the Executive Team meeting of the 27 September 2017. A further update was provided to a confidential Trust Board meeting on 14 November 2017.

24. As I have referred to above, from November 2017 on monthly safety reports were developed and presented to Trust Board by the service director, supported by the Directors of Nursing, HR, Social Work and the Medical Director as required.

25. In addition to appearing as a standalone agenda item from November 2017, issues relating to MAH would also appear at both Trust Board and Executive Team meetings. The Trust Board deals with a range of issues that are of Trust-wide significance, and MAH may be referenced or included within the papers provided to those meetings. Even if MAH is not specifically mentioned, the agenda item in question may be relevant to MAH, in tandem with a range of other Belfast Trust services. For example, the Capital Evaluation Committee reports are routinely considered by the Executive Team. Those reports provide detail on projects requiring capital expenditure throughout the Belfast Trust. Reference to MAH would be included within the papers on those occasions where funding was sought to undertake works at MAH. Similarly, the Executive Team would consider papers concerning Trust-wide procurement issues that would also pertain to MAH, among other services. In this respect, MAH is treated no differently from any other service within the Belfast Trust. I present a weekly Healthcare Associated Infections update to the Executive Team to track instances of MRSA and C-Difficile throughout the Belfast Trust. Those updates now report the number of healthcare acquired infections within the Adult Social and Primary Care Directorate, including MAH (although numbers for MAH are not separated out from the divisional total). The Executive Team and Trust Board therefore routinely consider matters relevant to MAH, or which touch upon the service provided there, which also relate to a wide range of other services within the Belfast Trust. In these respects, MAH is treated the same as any other individual service within the Belfast Trust.

Question 4

Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

26. I was a regular visitor to MAH since my appointment in 2010. I can no longer recall specific dates or times that I attended, although I hope to be able to provide some general information about the occasions on which I attended the MAH site. I first attended MAH as part of my induction, in order to meet the team working there. I also attended senior nurse meetings and undertook quality and safety visits on specific wards.

27. The purpose of the senior nurse meetings was to give me an opportunity to meet with the nursing team and to speak to staff who were working on the ground at MAH.

28. The safety and quality visits were 'leadership walkarounds', where Directors from the Belfast Trust Board would attend various sites within the Belfast Trust. This was done on a rolling basis, and members of the Trust Board would try and visit a wide range of the many services throughout the Belfast Trust's remit during the year. The purpose was to allow Trust Board members to attend a wide range of services, to speak to staff there and to listen to their concerns or comments about how the service was running. I can see from my diary that I also visited MAH on 31 July 2017, accompanied by Esther Rafferty and Mairead Mitchell. The visited lasted 3 hours and involved meeting senior staff and touring some wards. The Executive Team meeting took place at MAH just 2 days later, on 2 August 2017. Again, I would have visited wards while on site. I can say that I did not see any behaviour by staff that caused me any concern on those visits, and no concerns about the behaviour of staff were raised with me. As an aside, I can also see I visited Iveagh with Esther Rafferty on 17 August 2017.

29. I also attended MAH as part of Executive Team and Trust Board meetings, afterwards meeting with staff and patients. I know this included meetings that took place at MAH in February 2016 and August 2017. I also recall a Trust Board

meeting taking place in circa 2010, the chair at this time was Mr Pat McCartan, but I cannot locate the precise date.

30. Following the matters that emerged in later 2017 I attended weekly meetings at MAH with the service Director and HR Director, providing staff with an opportunity to meet with the senior team and raise any issues they may have.

31. At one Trust Board meeting in December 2020, the Trust Board responded to questions from members of the public who attended the meeting. One question related to how many times each Non-Executive and Executive member of the Trust Board had visited the MAH site. I see from the minutes of that meeting, which are exhibited behind Tab 3 in the exhibit bundle, that I was noted as having visited on 17 + occasions.

Question 5

Did the Trust Board receive reports on the following (and if so, please indicate how often):
i. Safeguarding of patients at MAH.
ii. Seclusion rates at MAH.
iii. Complaints relating to MAH.
iv. Resettlement of patients from MAH.
v. Staffing (both establishments and vacancies) at MAH.

32. Prior to adult safeguarding concerns being escalated to Trust Board in later 2017, the Trust Board would not routinely have received reports on matters such as these, nor would it have received such reports in relation to any other service area within the Belfast Trust. The issues set out in the question are principally matters that would be dealt with at Directorate level, albeit the Director (or any other relevant person) would have been able to raise any areas of concern to the Trust Board as required.

33. That changed after adult safeguarding concerns came to light in later 2017, at which time MAH became a matter of particular concern to the Trust Board. The

MAH operational team completed reports on a range of matters in one composite report which came to Executive Team regularly and to Confidential Trust Board monthly. The Executive Team would receive a weekly update on MAH that would include, among other things, updates on issues such as those set out above. Although a weekly report would not necessarily include all of the information set out above, discharges, workforce issues and related matters would regularly appear in the update. I have exhibited a series of Executive Team minutes to demonstrate the sorts of matters that would be included. These can be found behind Tab 4 in the exhibit bundle.

34. This report was then shared with Department of Health colleagues and reviewed for sharing with MDAG (Muckamore Departmental Assurance Group) after its formation in or around 2019.

Reports on the Safeguarding of patients at MAH

35. As with the other categories of report set out in the question, the situation following the escalation of MAH to Trust Board in later 2017 is quite different from the situation prior to that point in 2017. The Trust Board would not routinely have received reports on the safeguarding of patients at any individual service or hospital, although it may have considered broad reports on the safeguarding of patients throughout the Belfast Trust, such as through the annual report on Delegated Statutory Functions. This changed for MAH after serious safeguarding concerns came to light in later 2017.

36. The normal management of adult safeguarding concerns sits within the relevant directorate. So, in the case of MAH, it is delegated to the service director for MAH, as demonstrated in the assurance structures for the Belfast Trust. However, the Divisional Nurse, previously known as the Associate Director of Nursing, would have reported issues involving MAH nursing staff at the monthly Senior Nursing Management Team meeting or would have escalated issues of concern to my team for advice as evidenced in the Ennis incident in 2012, such issues would then have been addressed through fitness to practice processes. Overarching adult safeguarding reports were not routinely presented prior to September 2017.

37. A Trust wide live governance report was developed over 2017 and was then rolled out across the entire Trust from October 2018. This report was shared with Non-Executive Directors and the Chair at that time. This approach has recently been revised at the request of the current chair and new Non-Executive Directors.

38. The MAH weekly sitrep reports informed the reports that were summarised to Trust Board and recorded all incidents including safeguarding, staffing, seclusion rates, complaints and use of sedation. This has further been developed to include historical and contemporaneous CCTV viewing, and progress with resettlement.

Reports on seclusion rates at MAH

39. As above, the Trust Board would not routinely have received reports relating to seclusion from any service area of the Belfast Trust. However, the MAH SITREP reports, that were developed through 2019, reported on seclusion rates.

Reports on Complaints relating to MAH

40. As above, this information would not routinely be provided to the Trust Board, however complaints are recorded in the MAH weekly safety report as noted above, the Trust Board report and in the Trust Assurance Committee Complaints report.

Reports on Resettlement of patients from MAH

41. As above, the MAH SITREP report included information relating to resettlement of patients, however this information would not routinely have been provided to the Trust Board in relation to MAH, or any other individual service area, prior to the mechanisms set out above being put in place.

Staffing (both establishments and vacancies) at MAH

42. Nurse Staffing establishments and vacancies are in the MAH weekly report noted above. From early 2018 the Divisional Nurse provided a weekly staffing update to

the service Director and to me as Director of Nursing. My workforce team supported the directorate in the development of work force models to meet patient needs and to address the vacancy risks from 2018. This included the recruitment and development of agency workers to stabilise the nursing workforce at MAH. This was in addition to the bi-monthly workforce meetings which were core business for SNMT.

Question 6

If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

i. Who prepared those reports?

ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?

iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

43. Before the events of Autumn 2017 there were no regular reports about safeguarding, resettlement or staffing in MAH to Trust Board, although complaints would have been reported to the Trust Assurance committee as part of the Trust complaints report. Escalation would have been via the service Director for MAH as previously noted.

44. Following the escalation of MAH in late 2017, weekly reports were developed and prepared by the learning disability management team, evolving as described above. This information was provided to the Executive Team and the Trust Board to inform debate and discussion. I personally would have accounted for the processes around staffing, regulation and fitness to practice as required.

Question 7

Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

45. I became aware of the concerns in September 2017 on my return from leave, following an update from the then service director, Mrs Heaney. I updated the Chief Nursing Officer and or her team as the situation evolved.

46. I engaged an external team in late 2017, who commenced in January 2018 to seek external independent assurance about the safety of care in MAH. This team of three people was composed of the Trust Adult Safeguarding Specialist, Yvonne McKnight, a Learning Disability Expert Nurse, Professor Owen Barr (Ulster University) and Mrs Frances Cannon (Northern Ireland Practice & Education Council for Nursing and Midwifery).

47. The service director and I developed the project outline for the following areas:

    a. Review of the model of service delivery;
    b. Review of advocacy services;
    c. Nurse staffing levels, skill mix, training and education;
    d. Review of enhanced monitoring;
    e. Review of AS processes;
    f. Review of CCTV viewing.

48. This proposal was brought to Trust Board on the 11 January 2018.

49. In September 2019 Trust Board was briefed by the then Chief Executive, Mr Martin Dillon, that RQIA had issued three improvement notices in August 2019. An action plan was developed to address the issues of financial governance, adult safeguarding, and nurse staffing.

50. I worked closely with the oversight group to address the improvement notices. My deputy director was also based in MAH for the majority of her working time to add additional senior nursing oversight and to provide additional assurance to me on an ongoing basis.

Question 8

What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH?

Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

The arrangements in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH?

51. The operational management of workforce was undertaken at a divisional level, however particular work force concerns would have been raised by the directors or the Executive Directors if additional support or funding was required. For example, I spoke with the director about the need for Learning Disability to have its own associate director of nursing, which she agreed to and this was appointed (previously this was a shared post with Mental Health). Therefore, this issue was principally a matter for the Directorate in question, however the Trust Board would have considered any matters raised to it where there were particular concerns or queries raised.

My recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

52. In 2011, due to the resettlement plan, there was no permanent recruitment of nurses to MAH. I raised this as a concern and the staffing levels were reassessed. This led to permanent recruitment recommencing on my recommendation in 2012/13.

53. I commissioned a workforce review led by my workforce team and the MAH teams on a number of occasions resulting in a piece of work which was completed in early

2019. This had to reflect the level of complexity of the remaining patients, and their health care needs.

54. The Assistant Director of Nursing would have regularly brought workforce concerns along with other concerns to my Senior Nursing Management Team and workforce or FTP meetings, where we would have agreed an approach to these matters, and she would have escalated, or I would have followed up with her director as necessary. Issues would only be escalated to the Trust Board if there was a need to do so, for example the Directorate lacked resource to manage the issue itself. This was principally a Directorate-level concern and would only have become an issue at Trust Board level if there had been a need to escalate beyond the Directorate.

55. In 2019 with the impact of the staff suspensions, giving rise to instability of the workforce the Chief Nursing Officer offered the support of Francis Rice (former Executive Director of Nursing within the Southern Health and Social Care Trust) to work with the MAH team to review skill mix and support based on patient needs and to stabilise the site. This included a programme for agency staff to develop suitable key skills to care for patients in MAH and to enable them to take charge. This information was shared and discussed at Executive Team and at Trust Board, given the acute problems caused by the impact of staff suspensions at MAH.

56. In 2021 with the ongoing impact of suspensions resulting in Learning Disability nurse staffing availability being compromised, the Chief Executive arranged a "Risk Summit" to discuss the vulnerability of the service and to seek further regional support from fellow Trusts and other key stakeholders in the planning of any contingency requirements. The Belfast Trust team, of which I was part, emphasised the precarious nature of the services at MAH and resultant concerns on the part of patients, families and staff.

57. With the increasing vacancies at the MAH site, by 2020 the workforce was composed largely of agency staff. The DoH agreed to a 15% recruitment and retention premium for all staff. Other Trusts were also approached to provide additional Learning Disability staff for MAH, however this approach did not realise

many new staff and other Trusts' staff could not commit to working at MAH on a full time basis. The work to more fully integrate agency staff into the workforce was more successful and provided more consistent stability of the nursing workforce, albeit as agency staff.

Question 9

Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

58. The approach to cost savings was largely consistent until 2017, however the constraints which were applied to other services were not applied to MAH after this time due to the requirement to maintain the stability of the nursing workforce. An example is the use of high cost off-contract nursing agencies, which was stopped in all services except MAH, as this off-contract agency was able to supply consistent staff for MAH. This remains in place to this day.

59. As mentioned above, the Department of Health agreed to a 15% recruitment and retention premium for all staff, of all grades and professions working at MAH, however, this had minimal impact on staff recruitment and retention. However, it does demonstrate that the issue of staff retention was being taken very seriously, and that the Belfast Trust and Department of Health were able to make specific financial provision for the MAH workforce in light of the particular circumstances in play.

Question 10

From 2010 onwards, following bed closures at MAH:
i. How did the Trust Board assure itself that the reorganisation of wards was safe?
ii. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.

60. Workforce requirements in MAH for reconfiguration of wards were developed and designed by the Learning Disability team, which formed part of the Directorate in which MAH was situated. The Trust Board would not have been involved in the reorganisation of wards on any hospital site, including MAH, unless that issue had been escalated to it by the Director.

61. Support for staffing redesign and models of care was provided by my workforce team, usually at the request of the Directorate team, or at my request following escalation of needs and concerns through my professional assurance processes. This work informed business cases and proposals to the Public Health Agency (which was the commissioner for nurse staffing at this time).

62. I do not recall that these issues were raised to Trust Board level prior to late 2017, although the enhanced scrutiny of MAH following 2017 has resulted in more detailed information being escalated to the Trust Board in light of the concerns that have been raised in relation to MAH.

Question 11

Were any issues relating to MAH ever included in:

i. The Delegated Statutory Functions Report?

ii. The Corporate Risk Register?

If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

63. The Executive Director of Social Work presents the annual Delegated Statutory Functions report to Trust Board, and is responsible for the development, coordination and implementation of the social care governance arrangements and assurance to the Trust Board.

64. The Delegated Statutory Functions report is developed in line with the layout prescribed by Health and Social Care Board requirements to report on Statutory Functions in the Health and Social Care Trusts. Following presentation to Executive Team and Trust Board, this report is then presented to HSCB, annually,

now SPPG, for final sign off. Learning Disability has been included in the Delegated Statutory Functions Report since at least 2010. This report has evolved over time and in 2020/21 the section was much expanded. I understand the Belfast Trust has provided all DSF reports to the MAH Inquiry.

65. In relation to the Corporate Risk Register, I believe that issues relating to staffing, choking and resettlement may have been escalated although I cannot be precise about when that escalation occurred. The Corporate Risk register contains risks that apply across the Belfast Trust, and there may be certain risks, for example in relation to Learning Disability, that are relevant to MAH but which do not specifically mention MAH. For example, I believe that choking risks were considered to fall within the Learning Disability service generally, although those risks would have been relevant to the operation of MAH.

Question 12

Were SAIs which occurred at MAH always reported to the Trust Board? If so:
i. What information did the Trust Board receive in respect of SAIs?
ii. Were SAIs discussed at Trust Board meetings?
iii. What actions did the Trust Board take in response to SAIs?

66. Before 2018 SAIs were not routinely reported to Trust Board. These would have been managed through local directorate processes. Any SAI that occurred at MAH would have been managed within the Directorate, which is the case with any other service area.

67. After 2018, this would have been discussed at the weekly governance huddles chaired by the Deputy Medical Director. These would have been discussed at Trust Assurance Committee and at the confidential section of Trust Board.

68. Today, a summary of SAIs, brought by the Medical Director, is provided to the Executive Team and discussed at the weekly safety huddle.

Question 13

How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

69. The Trust Board received information on inspection reports from RQIA. Reports were received by the Chief Executive's office, as well as the Director of the Directorate to which they relate (where any improvements would be managed) and raised under any other business at Trust Board by the service director if necessary. RQIA inspects a wide range of facilities throughout the Belfast Trust, and the Trust Board does not individually review each RQIA report provided in relation to Belfast Trust services. The appropriate Executive Directors would support the Service Director on the development and oversight of quality improvement plans to meet the recommendations of RQIA reports. For example, in 2019 the improvement notices were addressed by this means.

70. In August 2019 the Trust Board was fully updated on the three RQIA improvement notices served on MAH in relation to staffing, adult safeguarding and financial governance. These were to be addressed by November 2019. The Trust Board were updated on progress on the 7 November 2019. Following a three-day inspection from 10-12 December 2019, RQIA lifted the staffing improvement notice in full and the adult safeguarding and financial governance improvement notices in part. The remaining parts of the improvement notices were lifted in full by RQIA in April 2020.

Question 14

Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

71. As Director of Nursing and User Experience I corresponded with the Chief Nursing Officer in relation to MAH as the circumstances required, and in line with the

professional requirement as a registrant on me to do so. Resettlement was core operational business and did not fall within the ambit of the Directorate of Nursing and User Experience, although I would advise the Director in question if there were any areas on which I could assist. I did speak to the Chief Nursing Officer Charlotte McArdle about staffing on occasion which resulted in the CNO offering a former Executive Director of Nursing and Chief Executive in the Southern Health and Social Care Trust (as well as being a former CNO), Francis Rice, to assist on the issue of staffing.

72. Following the events of 2017, the Trust Board, through its Executive Directors, regularly updated the DoH on matters pertaining to MAH. In 2019 the DoH developed the Muckamore Departmental Assurance Group ("MDAG"), chaired by the Chief Nursing Officer and the Chief Social Worker, which provided a forum for regular dialogue between the Belfast Trust, other Trusts, RQIA, advocacy groups and the DoH on matters pertaining to MAH.

Question 15

Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

73. I have no recollection of any discussion taking place at Trust Board regarding the installation and operation of CCTV at MAH, or at any other site in the Belfast Trust. It is possible that the business case for the installation of CCTV may have required capital approval, and this may have been raised at the Trust Board or Executive Team. If it was raised it is likely to have been together with a range of other capital projects occurring throughout the Belfast Trust.

74. After the events of 2017, and the findings arising from CCTV, this issue was taken to Trust Board as part of the regular safety briefings.

Question 16

Other than as addressed in responses to the questions above, 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 Trust Board level to address such concerns?

75. I was updated about concerns of allegations of abuse by the Associate Director of Nursing about the MAH Ennis ward in 2012. The Early Alert to the DoH was filed by my team. I was then involved in the response to the allegations. As I am responsible for taking regulatory steps in relation to registrants, I would also have received updates at Senior Nursing Management Team and at our fitness to practice meeting from the Divisional Nurse in relation to Adult Safeguarding investigations and actions taken by the team in respect of such allegations, as I would about other areas across the Belfast Trust where a registrant may have behaved inappropriately. The service team and director were also fully sighted on such matters and actions taken as a consequence.

Question 17

Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

76. I am personally aware of Winterbourne View, however I do not recall this being discussed at Trust Board. I would expect this matter to have been discussed within the adult protection team and at MAH by the senior team, but I was not involved in the type of discussions I anticipate may have occurred.

Question 18

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?

77. I think it is important to set out some further detail surrounding the governance structures that operate throughout the Belfast Trust and my role in relation to them. Although I am a member of the Trust Board, my role includes a number of assurance and governance functions that are not directly relevant to the Trust Board. Governance processes are delegated through Directorate governance structures and these report on all aspects of quality and safety within the organisation structure and steering groups to the sub-committees of Assurance Committee, then to the quarterly Assurance Committee of Trust Board.

78. Each service directorate has a well-designed governance structure, including Learning Disability, supported by a governance manager, to provide assurances to the above structures in line with all aspects of the safety and quality plan and the Quality Management System.

79. In my role as Executive Director of Nursing, I chair the Senior Nursing and Midwifery team meeting, which occurs monthly; the fitness to practice meeting bi-monthly; and Nursing workforce meeting bi-monthly. These meetings are attended by all divisional nurses, of which there are 14 in total, the senior nursing team from central nursing of which there are 6 in total, 4 senior nurses and 2 nurse advisors and the two Deputy Directors of Nursing.

80. Central nursing is part of the Directorate of Nursing and User Experience. The directorate is comprised of three divisions. These are i) Patients and Client Support Services; ii) Nursing Safety, Quality, Experience and Regulation; and iii) Nursing Workforce, Education and informatics. The latter two are regarded as Central Nursing. Each division has a member of staff at Band 8D who report to me; the Co-Director for PCSS and the two Deputy Directors of Nursing.

81. I also co-chair the Allied Health Professionals assurance group with the service director quarterly, which is attended by the lead AHP and all the heads of service.

82. I am lead director for the oversight and management of Health Care Acquired Infections (HCAI) and Antimicrobial Stewardship (AMS) and chair a monthly assurance meeting where all directorates including learning disability account for

performance. I also provide monthly reports for Executive Team, Bi-Annual reports for the safety and quality steering group and an annual report to the Trust Assurance Committee. I am also a Director of the Oversight Group for MAH and Chair meetings of the MAH Nursing Assurance Group. These roles all feed into the assurance and governance structures that relate to MAH which are not directly linked to the Belfast Trust's Trust Board.

83. I am the Trust lead for Augmented care, a group established to oversee the risk of Pseudomonas infection in augmented care areas following the Trust Pseudomonas outbreak in the neonatal unit Royal Jubilee Maternity Service, and learning from the Inquiry at that time. This group reports to the Trust Water Safety Group.

84. I undertake a number of regional work streams representing either Belfast Trust or the Directors of Nursing for Northern Ireland.

85. I plan to retire on 30 June 2024.

Questions relating to the "Way to Go" Report

Question 1

In relation to the Terms of Reference of the November 2018 report, "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital" ("the Way to Go report"):
i. Who wrote the Terms of Reference?
ii. How were the Terms of Reference determined?
iii. Why was the time period 2012 - 2017 selected for the investigation of adult safeguarding and subsequent investigations?
iv. Why was the time period August 2017 – October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?
v. Why was the time period 2012 - 2017 selected for the investigation of governance and quality assurance controls?

86. As responsibility for an SAI sits within the operational Directorate within which it is occurring, the Director of the service affected is responsible for the Level 3 SAI Terms of Reference. In this case that will have been Marie Heaney, then Director of Adult Social and Primary Care.

87. However, various communications from the time now available to me indicate that Ms Heaney had input from at least Ms Mitchell, then the acting head of Learning Disability services, various Belfast Trust Directors (including myself, although I don't now recall it), including through the Directors Oversight Group (which considered the Terms of Reference), the HSCB (who had to approve the Terms of Reference), Margaret Flynn, the independent chair of the Level 3 SAI, and the Department of Health. So, the Terms of Reference were determined through the collaborative effort of a number of individuals inside and outside of the Belfast Trust. If it assists the MAH Inquiry I can ask for such of the communications around the Terms of Reference that can be identified to be marshalled and provided to the MAH Inquiry.

88. Again, from the various communications I have seen to assist with answering this question (as I do not now recall the detail), the time period of 2012 to 2017 appears to have been selected because that included as far back as the Ennis investigation at MAH, a known previous incident of alleged abuse by staff. I can also see that on 30 November 2017, along with Ms Heaney, I attended a meeting with the DoH's Sean Holland and Charlotte McArdle, Chief Social Worker and Chief Nursing Officer, and on 30 November 2017 the two individuals sent a letter to Martin Dillon, then Chief Executive of the Belfast Trust, addressing a number of issues but that had the following passage relating to the Terms of Reference of the Level 3 SAI: *"We also believe the Trust now needs to review all allegations of abuse by staff over the last five years and the action taken by the Trust as part of its investigation. We therefore ask that this is now incorporated into the Terms of Reference for the 'Level 3' SAI investigation. As part of this, we also ask that the TORs include an examination of the failures to communicate the incident with the Department as well as the subsequent difficulties we faced in securing timely information from the Trust."*

89. I can see from the available documentation that the time period of August 2017 to October 2017 may have been referred to because this spanned the time period of the incidents that formed the 3 SAIs that were amalgamated into the Level 3 SAI; that is BHSCT/SAI/17/059, BHSCT/SAI/17/063 & BHSCT/SAI/18/002.

90. I am afraid I do not recall why the specific period 2012 to 2017 was chosen to look at governance and quality assurance, and controls in relation to quality, safety and user experience of care in LD services. However, I anticipate that this time period was chosen to match the adult safeguarding time period that was being considered.

Question 2

In relation to the 69 patient safeguarding files provided to the Review Team for the Way to Go report:
i. How, by whom and on what basis were the 69 patient files selected?
ii. Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefor.

91. Unfortunately. I do not know the answer to this question. I was not directly involved in the level 3 SAI. It may be Ms Heaney can assist further, or the likes of Ms Rafferty. Ultimately it may require the assistance of the individuals who physically gathered the materials made available to Dr Flynn and her team.

Question 3

In relation to the 61 RQIA reports provided to the Review Team for the Way to Go report, how, by whom and on what basis were those reports selected? Were they complete reports?

92. For the reasons set out above, I do not know the answer to this question, as I was not directly involved in the level 3 SAI.

Question 4

In relation to the 12 patient experience interviews provided to the Review Team for the Way to Go report, conducted pursuant to an RQIA questionnaire:
i. Was this the total number of such interviews or a selection?
ii. Were the entire contents of the 12 interviews provided, or selected parts of them?
iii. How, by whom and on what basis were those interviews (or parts of them, if applicable) selected?

93. As above, I do not know the answer this question. I was not directly involved in the Level 3 SAI.

Question 5

How, by whom and on what basis were the 20 minutes of CCTV footage, shown to the Review Team, selected (see page 8 of the report)?

94. I do not know the answer this question. I was not directly involved in the Level 3 SAI.

Question 6

Paragraph 17 of page 9 of the Way to Go report refers to an undated "Business Case" for MAH:
i. Are you aware of when and by whom this document was written?
ii. Do you know how the number of beds said to be needed (115) was calculated?
iii. Can the number of beds said to be needed be reconciled with the view expressed in the Bamford Review and Equal Lives that learning disability services should be community based?

95. I do not know what document this is, when it dates from, or what its premise was, so I am afraid I cannot answer this question. In the communications I have seen

to try to answer the questions asked by the MAH Inquiry I can see that on 24 January 2018 Dr Flynn was provided with a series of documents by email, including the January 2017 strategic outline case which was a proposal to reduce the 87 commissioned beds at MAH to 52. It may therefore be the reference in Dr Flynn's report is a mistaken one in that it refers to a much earlier business case (I note the reference to the Eastern Health and Social Services Board, which did not exist after 2009).

Question 7

Dr Flynn gave oral evidence to the Inquiry on 25 May 2023 that the data at paragraph 55 of the Way to Go report was taken from information supplied by MAH (see the transcript of 25 May 2023 at page 43). How and by whom was this data compiled and calculated?

96. For the reasons I have given above, I cannot answer this question. I was not directly involved in the Level 3 SAI.

Question 8

On the same date, Dr Flynn gave oral evidence to the Inquiry that the Review Team believed that the Report would be published (see the transcript of 25 May 2023 at pages 10-11). In relation to the issue of publication of the Way to Go report:

i. What was the Trust's view regarding publication of the report at the time of engaging the Review Team?

ii. Did this view change? If it did, why?

iii. When and how was the Trust view regarding publication communicated to the Review Team?

iv. When, if at all, was a decision taken by the Trust to leave the report unpublished?

v. Who made this decision?

vi. When and how was this decision communicated to the Review Team?

vii. For what reason(s) was the report left unpublished?

97. I do not know why Dr Flynn thought an SAI report would be published. I have never known an SAI report to be published, whether in the Belfast Trust or anywhere else. They are shared with HSCB, the DoH and with the families affected by them, but they are not a public document. Ms Heaney will probably be best placed to answer this question, but I would be highly surprised if any consideration was given to publishing the SAI report, that has never happened in my experience.

Question 9

In relation to the shorter Way to Go "summary" report, which was published in or around February 2019, Dr Flynn has given evidence to the Inquiry that she did not write it (MAHI-STM-130-1). In relation to this summary report:
i. Who compiled it?
ii. What were the circumstances leading to its compilation?

98. I am afraid I cannot answer this question. I was not directly involved with this SAI. I expect there will be emails that evidence the creation of this summary version and I note that when it was published on the website of the Belfast Trust on 15 February 2019 (https://belfasttrust.hscni.net/2019/02/15/summary-of-a-review-of-safeguarding-at-muckamore-abbey-hospital-a-way-to-go/) the introduction to the summary said as follows:

> *"In response to reports of inappropriate behaviour and the alleged abuse of patients by some staff in Muckamore Abbey Hospital, the Belfast Trust commissioned an independent team to undertake a Serious Adverse Incident (SAI) review to examine safeguarding practices at the Hospital between 2012 and 2017, chaired by Dr Margaret Flynn.*
>
> *The final report was received in November 2018 and it has been shared with affected families, staff and key stakeholders during December 2018 and January 2019. SAI reports are learning documents containing patient- and family-sensitive information which are not appropriate to share in full and they are not published; however, the Trust committed to publishing a summary of the document at the earliest opportunity.*

A comprehensive Summary of the Review, compiled by the Chair of the review team, is now publicly available at the link provided, detailing what the review team found; important considerations; lessons identified and recommendations by the team, patients' families, hospital staff, Trust senior managers and the RQIA. An easy-read summary is also provided.

The Trust reiterates its unreserved apology to those families who have been affected by staff behaviours which fell significantly below professional standards and our profound regret in letting patients and family carers down.

The Trust gives its full assurance that it welcomes ongoing scrutiny and is committed to ensuring that patients are cared for safely in the hospital, a positive way forward is provided for patients and families and that the recommendations in the review are realised.

There is an ongoing PSNI investigation into the allegations at the hospital which has not yet concluded.

<u>My role as Belfast Trust Director of Nursing and User Experience</u>

Question 1

How often did you meet with the Senior Nurse(s) responsible for MAH?

99. I chair the Senior Nursing Management Team monthly which all divisional nurses attend, including the senior nurse for MAH. Following this meeting each month there are either a workforce meeting or a fitness to practice meeting, each bi-monthly, which again the divisional nurse will report to, and we address issues of workforce or fitness to practice.

100. In preparation for both meetings my team will support clinics with their teams for all clinical settings Trust wide.

101. I also meet with the senior nurses in MAH for specific issues such as MAH assurance in respect of historical and contemporaneous professional matters.

102. MAH senior nursing staff are fully represented at all my professional meetings such as HCAI, smoke free, care opinion, workforce, fitness to practice, safety and quality, bank utilisation, educational commissioning, informatics and rota management for example.

Question 2

By what means (and at what intervals) did the MAH senior nursing team report to you? What types of issues do you recollect being reported to you by the senior nursing team?

103. The MAH team reported to me formally monthly at Senior Nursing Midwifery Team meeting, fitness to practice and workforce meetings. Sample minutes that demonstrate the sorts of issues discussed at SNMT meetings are exhibited behind Tab 2. They also update at the MAH assurance meeting monthly in respect of historical and contemporaneous professional matters.

104. I have an open door and accessible approach and the senior nurses, including the Associate Director of Nursing, now Divisional Nurse, have ready access to me and my team at all times.

105. I attend senior nurse meetings at MAH regularly, as part of my Executive Director of Nursing role. Post the Autumn of 2017 I attended MAH weekly, normally with the HR Director and the service Director, to support the team of nurses. I undertook this for a number of months.

106. The senior nurses in MAH work closely with my team in respect of all aspects of their role, who will support them from a safety and quality, patient experience, regulatory, education, workforce and informatics perspective. This has been the case since my appointment in 2010 and remains so currently.

107. The Associate Director of Nursing responsible for MAH would alert me to any issues of concern, outside of the usual structured meetings described, when issues

arose and, for example, may need escalation to the Trust Executive Team or to the Chief Nursing Officer.

Question 3

How did you ensure that RNLDs adequately supervised the work of unregistered staff at MAH?

108. It is the responsibility of the individual RNLD to delegate appropriately and supervise the work of non-registered staff. We have a framework of delegation to support this. RNLDs are also required to supervise students and agency staff.

109. Each ward has a structure: ward sister/charge nurse, deputy ward sister/deputy charge nurse, staff nurses, senior nursing assistants and, where required, the skill mix is also augmented by bank and agency staff.

110. There is a nurse development lead who supports the ward sister and charge nurses in the delivery of education and practice programmes across the wards. There is also a practice education facilitator who supports ward teams and students in the delivery of practice-based education.

111. The student experiences are consistently well evaluated for MAH, I receive regular audit reports by means of assurance, which I also provide to the CNO.

112. There are three lead nurses who supervise a group of wards.

113. There is now a Divisional Nurse who reports to me as Executive Director of Nursing as described above and is a member of the collective leadership team in the processes described above.

114. I provide yearly supervision and revalidation reports to Trust Board, via the Assurance Committee. LD nurses, who are required to have regular supervision and go through revalidation every 3 years, form part of this annual report.

Question 4

During your time as Director of Nursing and User Experience, do you recollect raising any concerns in relation to MAH with the Trust Board? If so, please give details.

115. Prior to 2017 I do not recall raising any specific issues in respect of MAH at Trust Board, however I do recall supporting the Service Director when she raised issues in respect of Ennis. After 2017 I regularly reported from a workforce, regulation and safety perspective as outlined earlier in this statement.

Other Matters

116. Within the delegated authority approach of the Belfast Health and Social Care Trust I have always supported my colleagues in Learning Disability and indeed Trust wide in an open supportive and constructive manner.

117. I strive to develop and support the nursing and midwifery workforce across all specialities within the Belfast Trust and have worked consistently in developing the capacity of nurses and midwives at all levels.

118. I have led the development of Advanced nursing roles for Northern Ireland, writing the regional guidance.

119. I have played a major role in assurance for MAH, working within the Joint protocol to support the safety of patients, and ensuring consistent approaches to fitness to practice and regulation.

120. Whilst I could not have foreseen the extent of issues within MAH, from September 2017, I took immediate consistent and fair action to try to address what has been uncovered in respect of some nurses and nursing assistants who were working at MAH.

121. I remain committed to safe effective care of all patients.

Declaration of Truth

122. The contents of this witness statement are true to the best of my knowledge and belief. I have, to the best of my ability, either exhibited or referred to the documents which, collectively, I believe are necessary to address the matters on which the MAH Inquiry Panel has requested me to give evidence.

Signed:

Dated: **19 June 2024**

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MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

13 March 2024

By Email Only
Ms Brenda Creaney
Former Director of Nursing
Belfast Health and Social Care Trust

Dear Ms Creaney

Re MAHI Organisational Modules 2024: Request for Witness Statement

The Inquiry is currently preparing for the final phase of evidence. Please see enclosed a document summarising the ten organisational modules to be heard in this phase: Organisational Modules 2024.pdf (mahinquiry.org.uk).

It is anticipated that the Inquiry will hear evidence in respect of these modules in September and October 2024.

The purpose of this correspondence is to issue a request, in the first instance, for a statement from you that will assist the Inquiry in this phase of evidence. It should be regarded as a request by the Inquiry Panel for the purposes of Rule 9 of the Inquiry Rules 2006. The Inquiry acknowledges that you are also providing a separate statement for the purpose of its consideration of the Ennis report.

The Inquiry understands that you were Director of Nursing and User Experience in BHSCT between 2010 and 2021.

You are asked to make a statement for the following module:

M9: Trust Board

I have also enclosed for your attention a copy of the Inquiry's Terms of Reference. You will note that the module in respect of which you are asked to make a statement is primarily concerned with the evidence of those in key positions of responsibility for MAH, past and present, at Trust Board level.

Please find enclosed two sets of questions that the Panel wish to be addressed in your

statement ("Questions for Trust Board Members" and "Questions relating to the Way To Go Report"). It would be helpful if you could address those questions in sequence in your statement. If you do not feel that you are in a position to assist with a particular question, you should indicate accordingly and explain why that is so.

In addition, given your role as Director of Nursing and User Experience for BHSCT, the Panel would be assisted if your statement would also address the following:

1. How often did you meet with the Senior Nurse(s) responsible for MAH?

2. By what means (and at what intervals) did the MAH senior nursing team report to you? What types of issues do you recollect being reported to you by the senior nursing team?

3. How did you ensure that RNLDs adequately supervised the work of unregistered staff at MAH?

4. During your time as Director of Nursing and User Experience, do you recollect raising any concerns in relation to MAH with the Trust Board? If so, please give details.

Please note that, while the Inquiry has received and heard a considerable body of evidence about the relevant systems and processes that were in place during the timeframe of the Terms of Reference, the Inquiry will now be focusing primarily on the *adequacy and effectiveness* of those systems and processes.

Please see enclosed a Statement Format Guide that will assist with the presentation of your statement. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

You are requested to furnish the Inquiry with your completed statement by 27 April 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/apcwkz7f75cnww5gjd0go3hnelzmkwcf

Should you have any issues accessing BOX please email info@mahinquiry.org.uk and a member of the team will assist you.

Statements made for the purpose of the organisational modules will be published on the Inquiry's website.

As noted above, it is anticipated that evidence in these modules will be heard by the Inquiry in September and October 2024. If there are any dates in those months on which you will be unavailable to attend the Inquiry to give evidence, please inform the Inquiry as soon as possible by emailing the Inquiry Secretary jaclyn.richardson@mahinquiry.org.uk.

If you have any queries about this correspondence, please do not hesitate to contact me.

Yours faithfully,

Lorraine Keown
Solicitor to the Inquiry

Encs:

1. Outline of Organisational Modules April – June 2024: Organisational Modules 2024.pdf (mahinquiry.org.uk).
2. MAHI Terms of Reference.
3. OM2024 Statement Format Guide.
4. Questions for Trust Board Members.
5. Questions relating to the Way To Go Report.

MAHI Muckamore Abbey Hospital Inquiry

M9: Trust Board
Questions to be Addressed in Witness Statement

Questions for Trust Board members

1. Please identify:

   i. The time period in which you were a member of the Trust Board.
   ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).

2. Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?

3. To your recollection, how often was MAH included on the agenda of:

   i. Meetings of the Trust Board.
   ii. Meetings of the Executive Team.

4. Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

5. Did the Trust Board receive reports on the following (and if so, please indicate how often):

   i. Safeguarding of patients at MAH.
   ii. Seclusion rates at MAH.
   iii. Complaints relating to MAH.
   iv. Resettlement of patients from MAH.
   v. Staffing (both establishments and vacancies) at MAH.

6. If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

   i. Who prepared those reports?
   ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?
   iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

7. Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

8. What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

9. Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

10. From 2010 onwards, following bed closures at MAH:

    i. How did the Trust Board assure itself that the reorganisation of wards was safe?
    ii. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.

11. Were any issues relating to MAH ever included in:

    i. The Delegated Statutory Functions Report?
    ii. The Corporate Risk Register?

    If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

12. Were SAIs which occurred at MAH always reported to the Trust Board? If so:

    i. What information did the Trust Board receive in respect of SAIs?
    ii. Were SAIs discussed at Trust Board meetings?
    iii. What actions did the Trust Board take in response to SAIs?

13. How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

14. Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

15. Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

16. Other than as addressed in responses to the questions above, 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 Trust Board level to address such concerns?

17. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

18. 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?

MAHI Muckamore Abbey Hospital Inquiry

Organisational Modules 2024

M9: Trust Board
Questions relating to Way to Go Report

1. In relation to the Terms of Reference of the November 2018 report, "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital" ("the Way to Go report"):

    i. Who wrote the Terms of Reference?
    ii. How were the Terms of Reference determined?
    iii. Why was the time period 2012 - 2017 selected for the investigation of adult safeguarding and subsequent investigations?
    iv. Why was the time period August 2017 – October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?
    v. Why was the time period 2012 - 2017 selected for the investigation of governance and quality assurance controls?

2. In relation to the 69 patient safeguarding files provided to the Review Team for the Way to Go report:

    i. How, by whom and on what basis were the 69 patient files selected?
    ii. Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefor.

3. In relation to the 61 RQIA reports provided to the Review Team for the Way to Go report, how, by whom and on what basis were those reports selected? Were they complete reports?

4. In relation to the 12 patient experience interviews provided to the Review Team for the Way to Go report, conducted pursuant to an RQIA questionnaire:

    i. Was this the total number of such interviews or a selection?
    ii. Were the entire contents of the 12 interviews provided, or selected parts of them?
    iii. How, by whom and on what basis were those interviews (or parts of them, if applicable) selected?

5. How, by whom and on what basis were the 20 minutes of CCTV footage, shown to the Review Team, selected (see page 8 of the report)?

6. Paragraph 17 of page 9 of the Way to Go report refers to an undated "Business Case" for MAH:

   i. Are you aware of when and by whom this document was written?
   ii. Do you know how the number of beds said to be needed (115) was calculated?
   iii. Can the number of beds said to be needed be reconciled with the view expressed in the Bamford Review and Equal Lives that learning disability services should be community based?

7. Dr Flynn gave oral evidence to the Inquiry on 25 May 2023 that the data at paragraph 55 of the Way to Go report was taken from information supplied by MAH (see the transcript of 25 May 2023 at page 43). How and by whom was this data compiled and calculated?

8. On the same date, Dr Flynn gave oral evidence to the Inquiry that the Review Team believed that the Report would be published (see the transcript of 25 May 2023 at pages 10-11). In relation to the issue of publication of the Way to Go report:

   i. What was the Trust's view regarding publication of the report at the time of engaging the Review Team?
   ii. Did this view change? If it did, why?
   iii. When and how was the Trust view regarding publication communicated to the Review Team?
   iv. When, if at all, was a decision taken by the Trust to leave the report unpublished?
   v. Who made this decision?
   vi. When and how was this decision communicated to the Review Team?
   vii. For what reason(s) was the report left unpublished?

9. In relation to the shorter Way to Go "summary" report, which was published in or around February 2019, Dr Flynn has given evidence to the Inquiry that she did not write it (MAHI-STM-130-1). In relation to this summary report:

   i. Who compiled it?
   ii. What were the circumstances leading to its compilation?

SENIOR NURSING & MIDWIFERY TEAM MEETING
Friday, 21st July 2017 at 9.00 am in Boardroom, A Floor, Belfast City Hospital

Present:	Brenda Creaney, Chair Gabby Tinsley Esther Rafferty Moira Kearney Mel Carney Geraldine Byers Angela Pollock	Irene Thompson Brenda Kelly Heather Jackson Nuala Toner Joanna McCormick Aisling Pelan
Guests:	Caroline Lee, Head of CEC Glen Lyttle, Lead Nurse Governance & Patient Experience	
In Attendance	Rosaleen Magill	

Item	*Minute*	*Action*
1.0	**Apologies:** Apologies were received from Moira Mannion and Karen Devenney.	
2.0	**Minutes of the Previous Meetings**: The minutes of the last meeting of the 16th June, 2017, having been previously circulated, were agreed. Brenda Creaney welcomed Caroline Lee and Glen Lyttle to the meeting. She outlined the structure within Nursing within the Trust. Brenda Creaney wished to thank Stephen Boyd and Trish McKinney for all their hard work.	
3.0	**Declaration of Interest** None	
4.0	**Matters Arising**	
4.1	**Dame Donna Kinnair** Dame Donna Kinnair visited the Trust on 15th June. Brenda Creaney thanked everyone involved in the visit and advised that she received letter of thanks from the RCN.	
4.2	**Update from Executive Team** Congratulations were extended to Dr Cathy Jack on her appointment as Deputy Director of Nursing and Caroline Leonard on her appointment as Director of Surgery & Specialist Services. Brenda Creaney updated the team on the following: **Delivering Care Together Update**: This is ongoing **Finance position 2017/18**: Financial budget now in place. Financial plans now submitted to the PHA. Bids gone forward for any additional 'new' monies. Challenge 3 days with Seamus McGirr: This went very well and a business case submitted in relation to the Control Room.	
4.3	**Update from CNO Business Meeting:**	

Professional Guidance Supporting Consultant Nurse & Midwifery Roles and Project Report: Brenda Creaney chaired this group. Recommendations made by Brenda Creaney and Cathy McCusker which were agreed by all.
Neighbourhood District Nursing: Paper produced along with Mary Hinds, Mary Frances McMullan, Rose McHugh. Paper based on the principles of Buurtzorg and making every contact count. Group agreed that this needs to be a regional approach and worked the same way in all areas.
EITP: Una Turbitt attended the meeting to discuss.
Draft Leadership Strategy: Deadline for the end of summer to finish this work.
Update on Involvement in Transformation Workstreams – This work is progressing..
GP Update: Contingency for GPs
N&MTG: Eileen McEneaney is joining this group as DoN representative.
Trauma Network Board Meeting. Need Executive level nurse on network – Brenda Creaney to speak to Bernie Owens and Aidan Dawson in relation to who sits on the network. The bed model was shared with Mary Hinds. **Action: Brenda Creaney**
ECG Budget: £1.8m was not granted for the ECG budget and £1.2m has now been put back in. This is still below the original allocation which is short of what is needed by nearly £2m. Tight procedures need to be followed and any money needs to be used for its designed purpose only.
Assembly: Still in suspension

4.4 **CEC: Caroline Lee** updated members and advised: reduction in ECG accounted for approx. 5% of CEC budget. CEC producing a paper on how things stand and future sustainability. 8% and 17% increase in Nursing and AHP workforce respectively, however, a 20% increase in demand for training. Induction programmes are particularly problematic. There is currently a DNA rate of 20%. Brenda Creaney to write to all Ward Sisters/Charge Nurses in relation to DNA and the cost of courses. Elish MacDougall to draft letter. Caroline Lee to be copied into letter. **Action: Elish MacDougall & Brenda Creaney**

Meeting to be arranged to the Directors of Nursing and Caroline Lee in August to look at same. Workshop took place on the 19th July with Leads.

4.5 **Divisional Nurses**

Congratulations were extended to the following who were taking up posts as Divisional Nurses: Debbie Wightman, Cancer & Specialist Services, Heather Jackson, Unscheduled Care, Joanna McCormick, Acute Services and Geraldine Byers, Surgery. The Children's and Trauma & Orthopaedic posts currently going through the recruitment process. Brenda Creaney advised that she was in discussion with regards the midwifery post and Adult Social and Primary Care.

4.6 **Role 8A Nurse Leaders**

Brenda Creaney updated the team on the Executive Team's comments. Brenda Creaney to speak to Bernie Owens who is taking this forward. Paper that was forwarded to Executive Team to be shared with the team.
Action: Brenda Creaney

4.7 **Croatian Visitors**

Elish MacDougall updated the team on the recent visit. She thanked everyone involved and feedback from the visitors was very positive and they enjoyed

their experience in the Belfast Trust.

4.8 **Syrian Refugees**
Aisling Pelan updated members on a meeting she attended on 20th July. Aisling Pelan to provide a brief for Brenda Creaney to bring to the International Nurses Steering group: **Action: Aisling Pelan**

5.0 Update from Associate Directors of Nursing/Midwife from their Directorates as follows:

5.1 Community Child Health:
Nuala Toner updated the team as follows:
Patient Safety & Quality
- A number of projects have been proposed for the SQB training including breast feeding and data processing within health visiting for core contacts (this is in keeping with the requirements for Trusts to take forward the action plan from the regional gain audit for Health Visiting), as we are over-subscribed. Awaiting outcome of submission.
- QI project on immunisation errors in GP clinics is now completed and the project shortlisted at the trust. (Quarterly review of incidents has shown a reduction in immunisation errors noted as we have increased the amount of support from band 5 staff ay the clinics).
- On-going review of school nursing service, vision planning with CEC to look at structures and service delivery currently and into the future.
- Divisional nurse job description at final draft with on-going Directorate meetings regarding Collective Leadership.

Patient Experience
- Increase in the number of compliments from breastfeeding mothers who were supported by the Breastfeeding Peer Support workers and the BFI lead and colleagues.

Professional Nursing
- Challenges with reduced numbers for commissioning of HV training (40 agreed, 53 identified).
- School nursing course and teacher practitioner courses for HV and SN not running this year.
- Succession planning for Band 7 nurses. Recent meetings with staff highlighting the need to develop this level of staff. **Action: Nuala Toner to have a conversation with Elaine Kehelly and Elish MacDougall**

5.2 Adult Social & Primary Care:
Mel Carney's report:
Patient Quality & Safety
RQIA unannounced inspection of Ward L carried out. In the main, a very positive report. A number of recommendations made including out of date policies. Seamus Trainor working on the Environmental Policy. Action plan in place to increase capacity of the substitute prescribing team to take additional injecting drug users of the waiting lists. Recruitment issues remain a challenge particularly problematic for Community Mental Health and recruiting Team Leaders.

Patient Experience
Admissions out of Trust remain a challenge and the lack of bed availability is affecting timeliness of transferring patients from general hospital beds to mental health beds. A number of QI initiatives are been taken forward to address this. **Action: Heather Jackson, Lorna Bingham and Mel Carney to**

meet to discuss this.

Professional Nursing:
Agreement in principle within mental health on collective leadership model although discussion required to determine if role should be stand-alone or include an operational management component. The second Community Mental Health forum took place with a presentation on communication, "team Talk" from Dr Olly Bannon, really well received by attendees.

Gabby Tinsley updated the team:
Patient Safety & Quality
Hospital COE Wards
HCAIs – Separate reports for Directorate specifically on HCAI now being returned weekly.
Ward 6 South: 1 new CDiff case confirmed 18th July.
Meadowlands 2&3: Outbreak meetings continue no new cases.
Meadowlands 3: RCA being completed on patient with CDiff as part 1b on death certificate. Patient was transferred from RVH. RCA completed on 17th July concluded appropriate management and treatment in both RVH and Meadowlands.
Stroke Unit: No new cases
Mater Ward C: No C Diff. 1 patient MRSA positive in leg wound.
RQIA action plan returns for 6 South and 7 North completed and submitted following unannounced inspection 8th June.

COE wards vacancies.
This will be discussed at the Nursing Workforce meeting. Significant concerns regarding number of vacancies across COE wards remain and despite being prioritised for recruitment only very small percentage will be filled. Separate meetings in service to discuss options and agree way forward this includes Nursing workforce and trade union representation.

Complaints
2 current complaints
Complaints 2 current complaint on going:
- 1 in 6 south – issues raised regarding nursing communication and discharge planning.
- 1 ward C Mater - relating to a pressure sore on discharge to a nursing home – on going.

Valencia - Knockbracken site
- Monthly unannounced ward inspections by ASM and case file audits on-going.
- Ward continues to experience difficulty covering shifts due to shortage of band 5 nurses.
  Currently under funded band 5 staffing level by 2.59 WTE, 2.0 WTE currently on maternity leave and one commencing end of June. Interviews held on 08.06.2017 resulting in recruiting 0.6 WTE .
- Margaret Devlin has highlighted that ward skill mix is non-complaint with CNO Standard. Following discussion with Co- Director and ADoN for service area, it was agreed the service will recruit a Band 6 and an additional 2 band 5 nurses. In the longer term, the development of an options paper on the future service model and location of the Dementia Inpatient Service and the normative staffing review in Mental Health will guide the long term staffing requirements for this service. Further interviews for band 5s held in July.

- No HCAIs in June.
- One complaint on-going. Ward Sister is liaising with the relative.
- Reduction in absence levels (May'17- 15% - June '17- 4%). Ward Sister and Acting ASM are currently working with HR to address sickness.

Community teams
Vacancies
Team managers /Nurse leads continue to meet weekly to review pressures across the teams. Staffing pressures are set to increase over the summer months. Currently band 3 HCA vacancies including sick leave 6.29 WTE. Vacant band 3 posts-3.29 WTE. Currently Band 5 SN vacancies, sick leave and maternity leave 22.2 WTE. Vacant Band 5 -9.06 WTE. Currently Band 6 19.5 wte District Nursing Sister/Charge Nurse caseloads empty due to long term sick leave, maternity leave and vacancies. Vacant Band 6 – 13.5 WTE.

District Nurse staffing remains as red on Directorate risk register. Gabby advised that they had to temporarily remove 3 of the 6 caseloads from Bradbury team and disseminate them across 3 other District Nursing Teams to ensure a safe and effective service over July/August. This will be reviewed September.

Band 6 DN S/Charge Nurse interviews productive, there are currently 13 on the waiting lists. 13 staff returning from District Nursing course in September2017. Unfortunately, 3 of these staff have had their study extended and will not return at this time. If all pass successfully, then we can fill these posts, until then all teams have been supporting each other with temporary movement of staff.
8 Nurse lead posts 3 of which are vacant. Recruitment drives to date have been unsuccessful. The remaining 5 x Nurse leads are now working in teams covering the caseloads. This will be reviewed in September.

There are a number of issues impacting on the recruitment and retention of the Band 6 District Nursing Sister/Charge Nurses within the Belfast Trust:
Band 6 caseload holders going to other Trust areas where they get a band 7.
Band 6 caseload holders and band 7 Nurse Leads also taking up posts with the NI Hospice as they are banded at band 7 with the District Nursing course and not requiring a Specialist Palliative Care qualification. NI Hospice posts, band 7 advertised again this week. These issues are impacting on the retention of District Nursing caseload holder's band 6. On-going meetings with Trade Union colleagues continue who have worked with staff and managers and have been very supportive.

Incidents
Increase medicines incidents identified in one team – (5 over short period of time) ASM conducting an investigation to gather information collated at the individual MEA's. Medication incident regarding controlled drugs. Awaiting report of investigation. Increased compliments for District Nursing Teams acknowledged. Reduction in complaints District Nursing. No outstanding responses at present.
Professional Nursing:
Ward Areas
Significant Professional Nursing issues identified across a number of COE wards in regard to management of HCAI, administration of medications, documentation, care planning, communication, leadership and culture. There have been a range of meetings held by Senior Managers including Service Director, Director of Nursing and Director of HR with staff to highlight

concerns and seek staff views on potential solutions.

A comprehensive action plan will be drawn up and will include issues highlighted through a number of independent investigations (not yet completed) Working with all service areas to improve compliance with mandatory training updates and review education commissioning. Potential for more funding for Dementia companions for all wards .Business case for development following discussion at SNMT.

Palliative & EOL workshops specifically for COE wards MDT staff scheduled in July. This was requested following Dying Matters week Palliative walk rounds.

Senior manager on Burdett Trust steering group and COE wards participating in project designed to improve Recruitment & Retention.

Valencia ward Lack of availability of band 5 nurses due to vacancies, sickness and inability of nurse bank to provide Band 5 RMNs through agency or off contract requests. As service is working with one band 5 on a significant number of shifts, there is a risk service could be left uncovered if a band 5 goes sick unexpectedly. Supervision compliance is challenging to achieve at this time due to staffing pressures on the ward, Ward Sister has managed to have supervision sessions with all band 5 staff, and is scheduling more in July. Service has attempted to put contingencies in place by contacting operational manager for other wards on site but the response has been that they are also facing their own staffing pressure. B5 posts are currently out again to recruitment, to include nursing students pending registration in the next 6 months in a new attempt to address the staff crisis. . Risk register updated to reflect staffing shortages.

Community
ICP/Trust Collaborative Appointment of New Community Consultant Diabetologist as part of enhanced Community Specialist Diabetes team. New DNS post also. All new staff will be in post August/September. New model of service delivery in draft and awaiting full agreement. Implementation of workforce Modernisation and Review delayed as no service improvement lead post in place - Post to be advertised next month. Continue very successful clinical exchange programme with NI Hospice. Programme evaluation available. Supervision compliance slightly improved action plans in place for those areas of poor compliance. Continue to work regional on Delivering Care Phase 3 Normative and District Nursing Framework. Working with PHA to enhance OPHAT services. Phase One Hospital, Phase 2 Primary Care. Presentation to be delivered at next IMPACT Meeting awaiting confirmation of date. Representation on Regional D/N Advisory group, Terms of Reference currently out to consultation with D/N Lead. Beginning work with GP Federations regarding arrangements for Primary Care prescribing.

Esther Rafferty updated the team:
Patient Quality and Safety
Ongoing issues with staffing deficits on all wards –HSCW band 3 posts have been processed to address the shortfall in staffing alongside further recruitment for Band 5 staff. This remains on the service risk register. Issues also arising due a number of staff taking up the health visiting course as learning disability nurses have been very successful again and community infrastructure investment which has led to staff seeking promotional opportunities. A number

of Datix reports have been completed re staffing levels – pressures arising from number of patients on 1:1 or 2:1 care and outreach to facilitate discharge to community placements. Band 5 staff in the community are leaving to go to other senior posts in other Trusts and this will need reviewed in context of staff retention. Only 2 posts are band 5 with rest all at Band 6.

Staff sickness in some wards is 2% however overall sickness was at 10% but this is now down 2% over the last three months and this downward trend is continuing.

Staff Incident whereby Band 5 staff nurse sustained injury to hip. Ongoing support given and work is ongoing to review supports available to staff following incidents.

Additionally 4 wards have received Quality Network accreditation status
Iveagh won the National Patient Safety Awards in July, 2017

SQB project in PICU was around daily safety briefings and this is being rolled out to all wards including the communications champion.

Patient Experience
The number of patients delayed in their discharge has shown a very small decrease in the last 2 -3 months. Outreach to new providers to build up their resilience and confidence is essential to success however this also put additional pressures on an already stretched workforce and staffing on the wards. I hope that continued support to the new schemes opening in next 3 – 6 months will positively impact on the number of patients on the wards.

Hospital plan is to further reduce reduce the number of beds and have less patients per ward but higher staffing ratios and skill mix to meet the acuity of the patient's needs.

The lack of strategic planning now that the Bamford phase is completed between the department of communities and department of health in respect of further new schemes to meet year on year demand is impacting on our ability to provide suitable community placements for individuals to be discharged with complex needs.

The patient experience is directly impacted upon as they can't leave hospital when medically fit, increasing number of safeguarding incidents between patients who no longer require inpatient care

Professional Nursing
Delegation of Nursing Tasks discussed, feedback provided form regional working group. Test sites for delegation framework to be confirmed as Learning disability and maternity services.

5.3 **Surgery & Specialist Services**
Geraldine Byers updated the team as follows:
Patient Quality & Experience
HCAI: Ward 3 South BCH: C Diff cases x 2 within 1 month. A third patient was PCR +VE/ Toxin –VE. Ribotypes for all patients different.
Outbreak meeting held and Action plan devised. Improvements in hand and hygiene weekly audits/ all actions being monitored by ASM. Follow up meeting being scheduled for the next 7 days.

Ward 6A Vascular RVH:

C Diff cases x 2 within 1 month. Ribotypes different.

CDiff Case 11T BCH:

Male patient aged 83 years old admitted on 4th July 2017. Sample taken for CDiff on 19th July. Positive CDiff result received. Local investigation tool sent to ASM for completion.

Staffing:

BCH: Urology

- 3 North remains closed due to vacancies. 2 Band 5 staff appointed to Urology awaiting checks.
- Band 6 advertised – due to be interviewed
- Urology Open day held 9th June – not well attended
- Urology Specialist Nurse recently appointed to vacancy

RVH:

Burns:

- Band 6 interviews 18th July (2.39 wte)
- 4 x Band 5 staff appointed to Burns- awaiting checks

Vascular

- Action plan developed by Ward Sister focusing on developing knowledge and skills of staff.
- Band 6 – Advertised, now closed
- 2 x Band 5 staff appointed to Burns- awaiting checks
- Staff member on restricted clinical duties, supporting with teaching/ supporting new staff.

Cardiothoracic:

Theatres

- 4 x Band 5 staff appointed to Cardiothoracic Theatres - awaiting checks
- Bid submitted to HSCB for 2 additional Band 5 posts

CSICU:

- 4 x Band 5 staff appointed to CSICU- awaiting checks

Cardiothoracic Ward 5A:

- 6 beds currently closed – Aim to have beds for 5 days/nights from September. Exploring news models of flow on the Ward
- 2 x Band 5 staff appointed to Ward 5A- awaiting checks
- Rotation programme to be offered to newly appointed staff between CSICU and Ward 5A.

General Surgery*:*

EMSU:

- Sickness issues now resolved
- 7 Vacant posts in recruitment process
- 7 x Band 5s appointed to EMSU

MIH:

ESU:

- Issues with sickness in July (2.0 wte) + 1.0 WTE on maternity leave.
- Support from Ward F. Ongoing monitoring by ASM/SM on a daily basis.
- Review of patients being allocated to ESU on a daily basis – minimize unscheduled admissions.
- Situation may necessitate closure of beds in the coming weeks.
- 1 X Band 5 appointed to ESU awaiting checks

Ward F:

- 1 X Band 5 appointed to Ward F awaiting checks

Renal Nurse Staffing:
11 South: Unavailable/ Vacancies = 8.5 WTE
11 North: Unavailable/ Vacancies = 11.0 WTE
Dialysis Unit = 11.55 WTE

Staff from the units/ home therapies and OP are helping to fill the gaps Work has been done to get the staff paid weekly and will keep the gaps filled until the vacancies are filled. The situation will resolve September/October. Consideration may need to be given to closing a small number of beds in level 11 to ensure safe staffing levels are maintained. However every attempt will be made to avoid this by staff working together across the floor and efficiently using what staff there is available.

Patient Experience:
Surgery is now part of a UK wide Patient Experience Collaborative. This will involve getting real time patient feedback which will enable identification of areas of good practice as well as areas for improvement. An initial internal meeting has taken place to discuss overarching principles; however the detail is still to be worked through regarding the project which will last for 1 year. Vascular Surgery will be the area focused on initially.

Professional Nursing:
Nominations have been requested from the Directorates to participate in some follow up work after the Nursing documentation workshops that were held in May. The focus for the subgroup will be to:

- Review existing documents in relation to Governance – Inclusion of Version/ BHSCT owned/ Guidance for use if required (Minimum requirements)
- Develop some guiding principles for how we introduce/ monitor and decide when to stop using these forms.

It has also been suggested to:
Undertake a one day snapshot of 10 patients on as many wards as possible to look at completion rates of all bed end documents.

- Discuss the remit of the Nursing Documentation Group
- Consider the need for nursing representatives to be involved in the development of documents that they are asked to complete
- Send a proposal to the Executive Director of Nursing on all the work undertaken.

5.4 Specialist Hospitals & Women's Health:
Moira Kearney updated the team:
Workforce: There are a number vacancies in all areas. Regional recruitment for Paediatrics continues with ongoing issues.
HCAI: This is on-going. She updated members on the measles incident in Paediatrics. PHA facilitated a meeting last week.

Trauma Ward
Moira Kearney advised that the Telford model for 6 beds and 10 beds was sent to the PHA. The current environment identified for a stand-alone model. For the 10 bedded unit, this would include 4 bedded bays x 2 and single rooms x 2, the

6 bedded unit would only have one 4 bedded unit.

Brenda Creaney to speak with Aidan Dawson and Bernie Owens with regards to the Nursing representative on the Trauma Network group. **Action: Brenda Creaney**

Paediatrics Dental and ENT: Awaiting formal report.
Brenda Kelly updated the team:
Patient Safety & Quality:
Governance review action plan on-going. MDT group lead by Brenda Kelly.
Patient Experience:
Johnston House refurbishments completed on 30th June but some issues with the lift which is currently not working. Estates in contact with the manufacturer.

Professional Nursing:
Nursing Recruitment Neonatal:
Recruitment on-going. Vacancies now at 20 with 10 new starts commencing once their registration is through. Neonatal ICU may need to consider capacity. Brenda Kelly in discussion with Heather Reid.

Some directional guidance sought in relation to termination of pregnancy changing and how can women access this? Direction asked from Richard Pengelley.

Anne Strathern is moving to the Redevelopment Office on the 1st September as commissioning Midwife for the new building.

5.5 Acute & Unscheduled Care:
Joanna McCormick updated the team:
Patient Quality &Safety.
- 2 patients remain in RICU with c diff. 1 new case in BCH ICU 16/7
- Hyponatraemia training audit taking place in critical care
- SQB applications
- Theatre QI day on 22nd June well supported

Patient experience
- Critical care - CCaNNI relative satisfaction survey this month.
- Reduction in commissioned course places means ICU will fall below the minimum standard (50% with ICU course)

Professional Nursing.
- 13 WTE posts approved for 2 extra ICU beds associated with trauma
- Vacancies in all areas with recruitment slow.
- Scope of IR nursing roles to be undertaken
- NID's in relation to Revalidation
- Life support commissioning monies no longer available. Cost pressure for resus service
- Practice issues arising from investigation

Geraldine Byers provided a report:
Patient Quality & Safety
HCAI remains a focus within the Directorate. MRSA Bacteremia case on Ward 5F RVH. An RCA to be arranged with clinical team to review the case to identify route cause of MRSA.
Outcome of RCA MIH Ward E in relation to Coif case: This was carried out on the 7th June with the clinical team regarding this patient's care. There is a need for more clarity around discussions with the Coroner about patients who die who are known to have CDiff. This is not currently recorded as a requirement in the CDiff

policy.
Staffing: Staffing remains a concern especially in Ward D, MIH, Ward E, MIH. Mater Open Evening being held on the 19th June, 2017 to showcase some of the services available on site.
Concerns regarding staffing in 7B, 7C and 5F, RVH.
Patient Experience:
Ward D MIH is hoping to pilot "End of PJ Paralysis" for patients who are medically fit for discharge but awaiting placement. This scheme involves getting patients up in the mornings and dressed in their normal clothes to promote a model of health and 'normality' rather than focusing on ill health by them continually wearing their pyjamas. There has been great success with this in many hospitals across the UK and wider. Plans are on-going to pilot Dementia companions across Wards D and E on the MIH site. Arrangements are being made for a group visit to Antrim Hospital where the role has been established.
Professional Nursing:
Nursing structures workstream subgroup meetings:
Performance and practice was held several weeks ago. Some issues for further discussion:

- Need to update the current Capability policy
- Suggestion for the need to define nurses in difficulty at different levels and the feedback mechanisms
- Opportunity at the Senior Professional Nurses Forum to discuss issues in a supportive/confidential environment
- Some issues such as "inappropriate use of social media", absence management and poor attitude are currently being dealt with through management lines; however, they have professional implications. Suggestion for these types of issues to also have a professional focus.

Second Nursing documentation workshops have been held looking at bed end documentation (17th & 24th May). Attendance from other Directorates also 51 attendees in total. Review of all possible bed end documents which amounts to 93. Discussion about type of documentation, process for introduction, ongoing monitoring and decision to stop.
Next Steps:
One day snapshot of 10 patients on as many wards as possible to look at completion rates of all bed end documents.
Subgroup to be identified to:

- Review existing documents in relation to governance – inclusion of version/BHSCT owned/guidance for use if required (min requirements)
- Develop some guiding principles for how we introduce/monitor and decide when to stop using these forms
- Discuss the remit of the Nursing Documentation group to ratify all nursing documents or documents to be completed by nurses
- Consider the need for nursing representatives to be involved in the development of documents that they are asked to complete
- Proposals to be presented to the Director of Nursing

6.0 Safety and Quality

6.1 **HCAI Update**
Members were asked to be vigilant and targets now received and sent to Directorates. The current performance is listed in the tables below.

7.0 People

7.1 **Nursing Workforce**: Nurse staffing and midwifery vacancies were on the principle risk register. Aisling Pelan will be meeting with the ADoN/Divisional Nurses to go through their Action plans and will be compiling a report for the 9th August, 2017. Brenda Creaney to take the report at the Executive Team on the

16th August, 2017. Brenda Creaney to meet again with the Directors to agreed action plans. **Action: Aisling Pelan**

7.2 **NDLs & Other New Roles:** To be discussed in September, 2017

7.3 **NMC Consultations:**
Members already received notification regarding NIPEC event on the 16th August. Members to send names to Rosaleen with regards to attendance and Elish MacDougall will forward names to NIPEC. **Action: All & Elish MacDougall**.

Elish MacDougall went through the consultation with members. She advised that the PEF team will co-ordinate events to help complete the consultation. Elish MacDougall will send word document to members. **Action: Elish MacDougall** These are all available at https://www.nmc.org.uk/about-us/consultations/

7.4 **Supervision/Revalidation**
The Supervision and Revalidation reports brought to the Assurance Committee and will be forwarded to the CNO by 31st July, 2017.

8.0 Correspondence
The following was already sent to members:
Policy & Procedural Arrangements relating to the Prevention and Management of Latex Sensitisation
June 2017 with all sites - version 16 - 120617
SQR-SAI-2017-028 (Acute) - Blood Transfusion and the risk of Transfusion-Associated Circulatory Overload (TACO)
RNLD Professional Forum - 28th June 2017
Impact Measurements of the NIPEC Preceptorship Framework for Nursing, Midwifery and Specialist Community Public Health Nursing in Northern Ireland
NMC education consultation launch
Three month consultation on revisions to the Standards of Good Regulation
GP Request
Nursing & Midwifery Task Group - Summary Communique of Meeting 24/05/2017
Royal College of Nursing: Northern Ireland update: week ending 18 June 2017
Continuing Healthcare in Northern Ireland: Introducing a Transparent and Fair System - consultation launch
New Guidance from RCN on Restraint and Consent
Impact Measurements of the NIPEC Preceptorship Framework for Nursing, Midwifery and Specialist Community Public Health Nursing in Northern Ireland
Royal College of Nursing: Northern Ireland update: week ending 25 June 2017
Letter re Completion of Coroner Inquest - Serious Incident 21.06.17 707
Nursing & Midwifery Task Group - Summary Communique of Meeting 24/05/2017
SQR-SAI-2017-028 (Acute) - Blood Transfusion and the risk of Transfusion-Associated Circulatory Overload (TACO)
Royal College of Nursing: Northern Ireland update: week ending 2 July 2017
Appointment of Senior Dementia Nurse Specialist
PHA Correspondence in relation to Confirmed Measles cases in Belfast Trust Area 3.7.17
Royal College of Nursing: Northern Ireland update: week ending 9 July 2017
Royal College of Nursing: Northern Ireland update: week ending 16 July 2017

9.0 Any Other Business

9.1 Retention of Nursing Staff meeting
Aisling Pelan to send out a date for this meeting. **Action: Aisling Pelan**

9.2 Ward Entrance Board
Glen Lyttle will contact members in relation to Ward Entrance Boards. Irene Thompson advised that he was scoping to see which areas required same.

9.3 Nursing Documentation
Irene Thompson advised that the new nursing documentation was now completed. She will send out same to members**. Action: Irene Thompson**

9.4 IV Labelling
Joanna McCormick advised that that RQIA carried out an audit and no response as yet. Irene Thompson advised that the updated information was sent out to all.

10.0 Date and Time of Next Meeting: The next meeting will take place **Friday, 18th August, 2017 at 11.00 am** in Training Room 1, Clinical Skills, Elliott Dynes, Royal Victoria Hospital

Senior Nursing and Midwifery Team meeting held on 15th February 2019 at at 9.00 am in the Boardroom, A Floor, Belfast City Hospital

Present: Brenda Creaney, Chair; Aisling Pelan; Orla Tierney; Joanna McCormick; Karen Devenney; Patricia McKinney; Paula Forrest; Moira Mannion; Gabby Tinsley; Heather Jackson; Debbie Wightman; Brenda Kelly; Geraldine Byers

In Attendance: Rosaleen Magill

Guest: Bespoke Training: Niamh Marley, Senior HR Manager & Lesley Allen, HR Manager

Niamh Marley, Senior HR Manager and Lesley Allen, HR Manager gave a bespoke training session to the team in relation to Disciplinary policy, investigation and panel member refresher training. She gave an overview of the disciplinary procedure "the three hats" – Hat 1: Manager/commissioner, Hat 2: Investigator and Hat 3, Panel Member.

Action: Niamh Marley to send presentation to R Magill to circulate to members. She will attach the PEACE model on a separate sheet along with the new terms of reference. If members have any questions about these to get in touch with the relevant case leads and assistant case leads:

- **Surgery & Specialist Services; Children's Community Services** – Niamh Marley and Niall Atkinson
- **Acute & Unscheduled Care**; **Specialist Hospitals & Women's Health –** Sally Thompson and Denise Taggart
- **Nursing & User Experience**; **Adult Social & Primary Care** – Claire Nellis and Alison McClenaghan

She will do another 1-hour session on being a panel member and is available to attend Directorate meetings if required.

No	Item	Action
1.0	**Apologies & Welcome**	
	The Chair welcomed members to the meeting. Apologies were received from Irene Thompson, Nuala Toner and Brona Shaw. She welcomed Orla Tierney to the meeting who was representing Mel Carney. She advised that the Assurance to the Director of Nursing in respect of Professional Issues meeting was cancelled and asked member if they wished the time to be spend looking at the Divisional Nurse Assurance Framework to the Executive Director of Nursing. Divisional Nurses expressed that they are sent everything within their Directorate and asked to do, attend many meetings and that they would welcome clarity on this and clarity of role in context of wider organisation. Brenda Creaney pointed out that the Divisional Nurses' Line Manager was their Director and they were professional accountable to the Executive Director of Nursing in relation to safety, nursing workforce, education and patient	

	experience and she looks to the Divisional Nurses to raise any concerns within their Directorates and with herself. The Chair also stated that the Divisional Nurse job description and summary had not changed since members were appointed and expressed her view that the only people controlling doing this is the Divisional Nurses. She advised that she was happy to sit down with Director colleagues with members to work through this. She also said that she felt that some members have still operational work, which was challenging the way they work. Paula Forrest stated that she felt that the role was not valued internally within the Collective Leadership team. Brenda Creaney then left the meeting and the remainder of the meeting was facilitated by Moira Mannion.	
2.0	**Discussion points in relation to the Assurance Framework**	
	The following formed the discussion: • Clarity of Work Streams • Outcomes/Work Plan • Data and source of that data • Variance Report submitted to SNMT • Use of 365 or Shared Folder • Work plan around clarity of role in context of wider organisation – if Divisional Nurses are clear about their roles then they would have a greater voice within the organisation • Function of meeting and clear direction • Clarity of role and expectation of role • Process of escalation and how to do this and what are the next steps and how to de-escalate • Biggest risk in this organisation: Nursing Workforce **The Senior Nursing and Midwifery Team is a strategic monthly meeting:** Meeting Etiquette: start of every meeting from the outset Senior Nursing and Midwifery Team not enough time to meet monthly perhaps once per week and need to know the purpose of the meeting: • Strategic Meeting (Monthly): Rotational Chair from within the SNMT with The Executive Director of Nursing having an Agenda Item to report on CNO business, Executive team business • Decisions decided within the organisation without the Divisional Nurses input into, e.g. Ward Thermometer • More Forward planning and thinking – have a year planner and need to get teams up • Collective Leadership - more of a collective voice within the organisation. Every month we have a long meeting – any benefit splitting meetings – two people co-chairing and time keeper Way of doing this: Join 9.00 – 9.30: social and at 9.30 am into meeting, it becomes more professional and not merge one meeting into another. The agenda is not achievable – we need to influence the agenda – challenge ourselves when given the opportunity to report by exception.	

	At the end of the meeting to have an outcomes on what achieved at this meeting. The question was asked: Does Brenda meet with the Director/Divisional and pre-appraisal – Meet annually with your Service Director and Director of Nursing to agree your job plan/clarity of role and what is objectives for the year going forward. Purpose of this meeting: It is the responsibility for each Divisional Nurse/Lead Midwife to report on their performance to the Senior Nurses/Midwifery Meeting. Assurance given by Divisional Nurse/Lead Midwife at the following meetings: HCAI, Safety Quality Steering Group, Nursing/Midwifery Bi-monthly Workforce meetings, Assurance to Exec Director of Nursing on Professional Nursing issues meetings (formerly known as NiDs): Report these issues to one of the Senior Nursing and Midwifery Team meetings – not every meeting – need to decide when/how Clear in relation to how to escalate to the Executive Director of Nursing and Action Plan from that, and want to see this in the minutes of this meeting. Need to understand what Divisional Nurse provide assurance on – is it down to the basics? What are the Work Streams within Central Nursing and provide feedback on with reference to Corporate Theme? **Action: Central Nursing Team Business Plan to be shared.** Divisional Nurses pointed out that there was a few things that needed to be looked at within the organisation: • IT Systems • Office Space **Action: Moira Mannion to draw up diagrams of the different meetings and draft assurance document to be circulated to members for comment before the next meeting on 15th March 2019. Terms of Reference to be also looked at the at next meeting.** Assurance Framework to Execu Senior Nursing and Midwifery Terms of R	
3.0	**Reports submitted by Divisional Nurses:**	
	Gabby Tinsley, Mel Carney, Brenda Kelly, Nuala Toner, Geraldine Byers, Patricia McKinney and Paula Forrest – **Reports attached to the minutes.**	
4.0	**Date and Time Next Meeting**	

	The next meeting will take place on the **19th April 2019 at 9.00 am in the Boardroom, A Floor, BCH.**	

Divisional Nurse Variance Report

Divisional Nurse: Gabby Tinsley **Directorate:** ASPC, Adult, Community & Older Peoples Division
Service Area: Community Health Nursing **Date:** February 2019

Patient Quality and Safety
District Nursing **Areas of concern** • Significant risk of closure to secondary care referrals and development of D/N waiting list remains due to the number of Band 6 District Nursing vacancies across the Trust. The management of patients being discharged from hospital is being closely monitored in order to prevent any delay; this work is being shared across District Nursing Teams and OOH. Staff are continuing to work to amber –step 2 on Business Continuity. • Accommodation & Parking at the Bradbury Centre has posed significant challenge in the delivery of care of patients and team morale. This has been graded high risk and has been escalated to Director level to identify an accommodation solution • Availability of staff to support Mobile working pilot due to Team workload activity **Vacancies** Total vacancy/absence all grades staff district nursing: 38.24 WTE staff- backfill 15 WTE- 40% vacancy overall Band 7 CHTM are **not** included in these figures. These figures would indicate a slight improvement in staffing levels from previous report in January 2019. Dundonald has the highest vacancy rate (12.6) across Bands. However start dates are due to be identified for 2 Band 5 staff starting toward end of February 2019. **OOH DISTRICT NURSING SERVICE** Service now commencing at 5pm to reflect 24 hr nursing care delivered across BHSCT. Daytime referrals being managed by core district nursing service. **ACUTE CARE AT HOME TEAM** 7 day IPT submitted through TIG. Not all staff will be in post therefore slippage. This will mainly be medical posts. Pharmacy post not progressing. 1x band 7 seconded to the ANP course – significant development of nursing role within this team – supernumery x 2years.
Patient experience
District Nursing Service user feedback collated during the District Nursing Clinical audits which is a quarterly cycle. Compliments total number – 50 in the last quarter (figures collated in December 2018). Complaints-0 **ACUTE CARE AT HOME TEAM** Service user feedback remains very positive. Data collated and reported monthly. No complaints **COMMUNITY SPECIALIST TEAMS** Compliments collated monthly as per compliments report and forwarded for collation to Complaints Team. 1 constituency enquiry response made (diabetes) 1 complaint from GP via the HSCB responded to (diabetes)
Professional Nursing

Community Health Nursing

- FTP x2 registered staff referred to Disciplinary.
- NMC – no referrals
- Amendment to Non-Medical Prescribing Policy 4.13. No further update or progress to date.

Multidisciplinary Team/Neighbourhood Nursing- Neighbourhood District Nursing Band 8a coach appointed and commenced post on 11/02/19
QNI training dates circulated by PHA .

District Nursing Framework –Sub Groups

  - **Regional KPI group** – Workshop held in January to scope KPIs and outcome measures
  - **Regional IT Group.** Initial meeting followed by further session in Jan to scope eCAT codes and proposed DN framework codes

- **CAT** An interim standalone Call Allocation system for remaining teams awaits internal Trust approval through New Technical Project Sub Group. The Regional CCAG board has given approval to progress. This will allow remaining teams outside of total mobile project to have access to an allocation system, which will release clinical time to care. Project board established January 19 to progress this work.
- Work ongoing with development and testing of Paris allocation tool – Staff Diaries. Next phase is user acceptance testing (UAT) prior to confirmation of suitability and progress to implementation of 2 pilot sites. Simultaneous roll out to other 6 teams of Yarra caseload allocation system (CAT) to address identified risks associated with time required for call allocation, missed call and medicines incidents.
- Education commissioning requests submitted.
- Supervision focus for final quarter on teams who still require 2nd supervision session
- CAG product review completed for moving and handling community appliances
- CAG commenced for Community beds.
- Contingency review in light of Brexit options for equipment stock.
- Regional Pressure Ulcer KPI submitted for 3rd quarter with improvement noted to 80% compliance with completion of skin bundle
- Regional DN KPI workshop took place 30th January to agree future – agreed outcomes i.e. Documentation, completion of MUST(??), Key worker palliative care, referral criteria.

Divisional Nurse Variance Report

Divisional Nurse: Mel Carney **Directorate: ASPC**
Service Area: Mental Health **Date February 15th 2019**

Patient Quality and Safety

Influenza Outbreak Ward K
Situation: 13/02/19

- 5 patients affected, 4 tested positive for Influenza A, 1 patient suspicious of Flu symptoms
  - 1 patient is now more than 24 hours asymptomatic of Flu.
- Ward fully occupied

Action:

- The situation in Ward K has been declared an Outbreak of Influenza A.
- The Ward is closed to admissions and discharges – Individual cases required for a clinical need should be discussed with Microbiology or the IPCT. There are **no closed beds** at present.
- All patients that have tested positive for Influenza or those with symptoms of Influenza have been isolated in single rooms with droplet precautions. Two patients with confirmed Influenza A are cohorted in the double side room.
- All patients in the ward are receiving prophylaxis for Influenza.

- Ward cleaning to be increased with a full clean occurring in the morning, a second clean including touch points in the afternoon and an evening clean of the shared toilets.
- Actichlor plus is being used in place of routine detergent
- Visiting policy to be strictly applied, visitors to be informed that there is an increased incidence of Influenza on ward prior to entering ward
- Patient movement around hospital to be minimised as far as possible – There should not be any group activities at present.

A meeting is to be held on Friday 15/02/19 to review the situation
NB: After the meeting the IPCT were informed about ward J:

- 1 confirmed patient with Influenza A in ward J who is being nursed in a single room with Droplet precautions. (known to IPCT)
- 2 new symptomatic patients reported today

IPCT advise:

- All symptomatic patients should be isolated in single rooms with droplet precautions.
- The Bay should receive a deep clean and curtain change.
- Ward J remains open to admissions and discharges at present.

Death of 26 year old in Ward J, reported as SAI, current investigation by PSNI, strong suspicion that visitor gave medication to deceased.

Patient Experience

CAMHS are training Service User and Carers in QI methodology to enable them to engage in QI projects.

Professional Nursing

Nursing Workforce challenges remain in Community Mental Health and CAMHS in particular. Work is progressing with the development of the Band 5 Community Nurse role. Nursing Supervision returns indicate that division will be meeting target of minimum of 2 sessions per year. Number of Transformation projects being taken forward, which will have the potential to impact on the services ability to maintain core services by recruiting mental health nurses to new roles at higher bands. Examples are RAID and Primary Care Partnership.

Significant projected overspend in Acute Inpatient Wards due to a combination of back fill, increase in special observations, temporary posts that will end when new inpatient opens (Senior Nurse 2 x Band 7 night duty, Project Nurses for New Build etc.) and the development of new model of care (PIPA). Service Manager and Division Accountant are meeting to develop a recover plan. Confident that the Division will come in underspent this year again as additional resource is set aside for cost pressures and there will be an underspend id community services.
Perinatal Masters Course commences 25th February, 5 places, mixture of staff from maternity, children’s and mental health services.

Divisional Midwife Variance Report

Divisional Midwife/Head of Midwifery: Brenda Kelly Directorate: Maternity , NNICU, Gynae, Sexual Health, ENT and SoD
Service Area: SH&WH Date: February 2019

Patient Quality and Safety

Gynae OPD

Dr Dolan and Dr Campbell have received training using the new Scanner on Saturday 2nd and Sunday 3rd February 2019 with patients having been contacted and appointments arranged. From Friday 1st March 19 we will commence the Urogynae Mesh Clinics and MDT meetings these will occur on a rolling monthly basis. Until extra theatre sessions can be secured on Belfast city site, as we have already been doing, any urogynae mesh patients

requiring surgery in BHSCT will be added to current Urogynae Theatre lists. We have met with colleagues in Pain Management, Psychology and Physio and once staff have been recruited into posts funded through IPT this joint assessment clinic will begin. We are hoping this will be before end of May 19.

Maternity

Induction of labour quality improvement work stream: has begun with recruitment of midwifery team complete however these staff will not be taking up roles until April 2019.Documentation in relation to guidance for outpatient Foley catheter induction is in draft form at present and being discussed. AMLU project is ongoing and activity continues to be monitored. Survey of midwives and obstetricians regarding skin to skin contact underway to inform quality improvement for BFI standards. The service is planning to " Go for Gold" BFI accreditation in 2019 however will be reaudited prioir to this in May 2019. Senior team members continue to undertake spot checks in all areas focusing on medicines security. SALTO locks are implemented in DS and Capital secured to roll this mechanism out across the Maternity service.

Recruitment of Midwives 23rd March agreed as date with support from HR Colleagues

NNICU: No further incidences of MRSA PVL in this area. Staff swabbing completed and it is hoped that the outbreak will be closed.

QI project continues focusing on the reduction of medicines errors.

5 South. Fluid balance audits noted reduced compliance with accurate completion. No further medicines incidents.

5S/ENT – Senior Nurse Meetings underway. Increased compliance with PPE and HH audits noted and monitoring continued.

No further medicines incidents ENT.

ENT Audiology agreement is being sought from PHA in order to close the issue and delays in the governance review in this area are being addressed.

Flu vaccinations have reached 43% in SHWH with peer vaccinators remain active across the services.

Patient Experience

Paediatric pathology

Changes communicated across the service and x 3 babies have been transferred to Alder Hay since 3/1/19. There have been no complaints received as of today.

Professional Midwifery & Nursing

25 approx vacancies identified in Midwifery with recruitment ongoing, bank usage continues. Recruitment day being undertaken in April in collaboration with HR Colleagues and discussion with QUB with regard to a regional job fair for midwifery recruitment. Midwifery recruitment to be added to the Trust recruitment plan and plans are underway to meet with HR colleagues to allow senior staff to offer posts at interview to improve our recruitment time scales. NNICU recruitment continues to band 6/5 posts. High sickness in this area is being carefully managed and B6 staff are most significantly affected leading to skill mix concerns and a persistent reduction in available cots which has been discussed with the neonatal network. Birth Rate Plus Workforce phase one report completed and shared with senior Colleagues. Senior Midwifery/Management team to review with a view to adding to the overall draft workforce document for the new Maternity hospital.

X 1 compliant involving a midwife requires further attention and this has been discussed with Irene Thompson and may progress to disciplinary processes.

Transformational monies identified for 5S for Band 7Ambulatory Gynae and Band 8a Service Improvement lead. EITP continues with positive responses and workstreams are in place to facilitate embedding this in the overall service provision. An acting B 7 Antenatal Education Coordinator has been appointed.

SUPERVISION FRAMEWORK FOR NURSING AND MIDWIFERY REVISED PROGRAMME APPROACH (no further update)

The following stages are proposed for the new approach:

- The Learning and Development Sub Group should remain in place due to the need to engage with educationalists and those who may deliver any future programmes. This will support the development of appropriate learning outcomes and curricula outlines for future learning and development programmes.
- The draft framework should be developed based on the prior work and evidence provided through the three sub groups.
- Two workshops should be convened; in a timeframe that aligns with the completion of the work of the Learning and Development Sub Group (a timescale between April and June 2019 is suggested). The purpose of the workshops will be to set aside two full days which all the Programme group membership will be invited to attend to test the draft framework. April - to review and amend, June - to finalise and agree. This should include any online resources developed.
- The final draft version will be tested in a small scale pilot in each HSC Trust including piloting online resources July - October 2019.
- October – December 2019 revision of the framework based on the small scale pilots.

RCM Position Statement – Midwifery Continuity of Care (MCOC)
This refreshed statement reaffirms our support for the aspiration that midwifery continuity of carer (MCOC) becomes the central model of maternity care. The statement also sets out the conditions that we believe must be in place to ensure that this model can be successfully and sustainably implemented.

Guidelines has been launched under the RCM's Midwifery Blue Top Guidance Programme**.**

FUTURE MIDWIFE
Local review of NMC Draft Standards for pre-registration midwifery programmes
Local review of NMC Draft Standards of proficiency for midwives.

Rotation in Midwifery
The "Principles for Rotation in Maternity Services" are for discussion with Moira Mannion
11 Expressions of interest forwarded for rotation with 9 B 6 staff being facilitated by the service at this time.

BK continues to meet with Gynae and ENT/SoD Nursing colleagues to explore ways to ensure Nursing Governance and professional issues have a platform for discussion with a view to establishing a Senior Nursing forum with the Division. Visits are also planned to ENT/SoD with Gynae visits ongoing.
An assurance framework has been developed and shared with teams for reporting purposes and has been agreed and reviewed favourably.

Divisional Nurse Variance Report

Divisional Nurse: Nuala Toner **Directorate:** Children's Community Services
Service Area: Comm. Child Health & Children with Disabilities **Date:** February 2019

Patient Quality and Safety

Community Child Health – position on 7/02/19

Vacancies

Health Visiting
- B7-1.0wte Parenting Support HV (from 21/01/19)
- B6-no funded vacancies however, 3.8wte from overfill, additional 3.1 wte pending
- B6-3.8wte M/L
- B6-3.95 wte S/L
- B5-0.38 wte vacancies (1.0 wte has been offered but candidate is on M/L until July 19)
- B5-0.8 S/L
- B3-Breast feeding Link worker
- B3- 0.93 overspend (1.71 wte EITP funding has now stopped)
- B3- 1.8wte M/L

Bank use is in place to cover some of the uncovered caseloads and is still being used to complete EITP 3 yr reviews within nursery setting. Some regular bank staff are currently unavailable which has depleted the bank workforce across Trust. Current significant difficulty is the cover for Immunisation clinics.

School Nursing –

Current situation – discussed between CSM and ASM and two weekly meetings are scheduled during this time. School Nursing added to Trust Risk Register and potential solutions being explored.

- B6 1.05 wte vacancy
  1.0 wte SCPHN secondment + 0.73 WTE s/l
- B5 1.65 wte vacancy
- 1.34 wte s/l
- 0.67 wte- seconded to SCPHN HV course (Jan 19)
- 0.5 wte unpaid leave for 3 months (Feb - May 18)
- 0.67 wte- seconded to SCPHN SN course
- 0.67 wte- m/l
- Recruitment- 0.67 wte B5 new start commenced on 1.2.19 +1 x pending new start 0.5 wte 1.4.19
- B3 0.8 wte vacancy- recruitment commenced

Bank usage required to deliver School Nursing although limited bank staff this year as regular staff are not revalidating/relocating. Bank usage as appropriate and within financial resources. Further B5 PHN interviews 8.3.18 to recruit into Imm team and SN team and create a waiting list

Immunisation Team

Vacancies

- B5 2.23 wte vacancies
  (inc 0.36 wte career break)
  vacancy pending – B5 - 0.67 wte (end Feb 19)
- B3 0.56 wte vacancy
  m/l 0.56 wte

**Bank usage required to deliver Imm programme against vacancies. Bank usage as appropriate and within financial resources .Imm team support school nursing team following completion of school Imm programme.

CCN team

Vacancies

- B7 1.0 wte– Paed Continence Advisor Post – pending advertising
  1.0 wte CCN TL
- B6 1.45 wte (inc 1.0 career break)
- B6 1.0 wte s/l
- B6 1.0 wte career break
- B6 0.73 wte CCN course
  - B5 2.72 wte vacancies – new start pending 1.0 wte 2.3.19
- B5 s/l 0.78 wte
- B5 m/l 0.43 wte
- B5 1.0 wte CCN course
  - B3 5.4 wte vacancies

CCN B5 interviews to be held on 12.2.19 – 5 applicants
Bank Usage as appropriate and within financial resources. Increased complexities within special schools requiring additional CCN resources.

Children with Disabilities

Vacancies

Forest Lodge currently has a 22 hr band 5 nurse post vacant. Which has been difficult to recruit. SMT are trying to identify resource to increase to 0.8 which will assist in the management of increasingly complex children.
We still need to recruit 1.8(temp) WTE in order to admit a child with acquired brain injury. This has gone back out for recruitment.

Safeguarding

- Capacity issues remain within safeguarding team and highlighted on Trust Risk Register
- 1.0 wte SCNS has accepted B6 HV permanent position.
- 1.5 wte SCNS vacancy – posts to be advertised
- LACNS remains on monthly monitoring report and no issues apparent.

Patient Experience

Community Child Health

- Three complaints were received in respect of HV service during November 2018. Telephone resolution for all 3 was successful. Compliments documented by admin staff
- Work continues on CMR Panel. Report due for submission to SBNI by end of year.

Children With Disabilities

Community Child Health

A current short break admission which is planned to become a long-term temporary admission for a child with ABI is going well. Staff are concerned that she requires more sensory stimulation and are consulting with Psychology colleagues about her needs. Plans are in place for a longer-term admission when staff are fully recruited

Professional Nursing

Community Child Health

- Five SCPHN students have commenced January 2019.
- Mandatory training is ongoing
- Supervisions and SDRs are ongoing

Children With Disabilities

One staff member is completing the Children's nursing course.
During a recent RQIA inspection staff were complemented by the inspector for the standard of recording and information management. The Inspector advised that there would be no recommendations or requirements.

Divisional Nurse Variance Report

Divisional Nurse: Geraldine Byers **Directorate:** Surgery and Specialist Services

Service Area: Division of Surgery **Date:** 15/02/19

Patient Quality and Safety

Update for Surgery

HCAI:

MRSA:

No MRSA cases in Surgical Division over past 12 months

CDiff Cases:

CDiff Case 2 North BCH:

74 year patient admitted on 10th December 2018 via RVH ED to BCH 7 North with V&D. Stool chart commenced. Patient went to theatre on 14th January for drainage of abdominal abscess, admitted to ICU post op and then to Ward 2 North to a sideroom on 15th January as ESBL in wound drain. Sample sent for CDiff on 12th February 2019 and positive CDiff result returned on 13th February. Care pathway commenced and treatment commenced. Local investigation tool completed by deputy ward sister. No issues with management identified.

Other Issues re 2 North:
There have been 3 patients nursed in 2N who have tested C.Diff toxin positive recently. All 3 patients were nursed in single rooms in the E-L section of the ward during their admission. The IPCT visited the ward on 14/02/19 and carried out a number of audits. Issues identified were highlighted at the time. Enhanced cleaning with Actichlor plus has been commenced in the E-L section of the ward.
The ribotyping of the most recent specimen has been expedited and the result is expected on 20/02/19. Members of the MDT have been made aware of the need to adherence to IPC practice. Further actions will be initiated on receipt of ribotype results.

CDiff Case Ward 2 South BCH:
84 year old admitted to hospital on 22nd January 2019, was treated in ICU and then transferred to 2 South on 4th February. IPC risk assessment completed on admission to 2 South which did not highlight any specific risks or history of diarrhoea. It was noted that the lady had received antibiotic treatment in ICU for hospital acquired pneumonia which was completed on 29th January. The lady commenced on oral co-amoxiclav for chest infection on 5th February which was then changed to IV on 7th February, then stopped on 9th February. When the lady started to experience loose stools, she was isolated in a sideroom and stool chart was commenced. A sample sent for CDiff on 8th February and positive CDiff result received on 11th January. Vancomycin was commenced on 9th February and CDiff carepathway commenced. Her antibiotic regime is being reviewed daily. Local investigation tool sent to and completed by the Ward Sister. All correct procedures followed in the management of this patient.

Patient transferred from Antrim to Ward 5A RVH (Case not reportable):
60 year old admitted to 5A on 30th January 2019 for CABG. IPC risk assessment completed on admission and patient accommodated in sideroom in light of previous CDIff diagnosis. Local investigation completed by ward team.

Increased incidence of GRE noted in 3 patients in Ward 5A RVH.
3 Patients affected.
Update following meeting on 4th February 2019:
- Patient x remains on the ward on B Bay
- Patient y discharged today
- Patient x transferred to LVH 30/01/2019

Actions:
- The two remaining contacts in B Bay to have a GRE screen today, IPCN to follow-up results.
- A decision will be taken on patient placement pending results from the screening.
- If possible patient x to be isolated with contact precautions and nurse special at all times
- Still awaiting typing results on previous isolates
- B Bay to have full terminal clean and curtain change
- All patients in B Bay to be managed with Contact Precautions

Further action will be dependent on screening results.
Update on other HCAI Related information:
4 X Cases of CDiff PCR Positive Toxin Negative in Ward 6A RVH since 11.01.19:
All IPC instructions actioned.
A meeting will be convened if required following receipt of ribotype results
No further cases identified.
MRSA:
No cases of MRSA in Surgical areas over the past week
HCAI Walkrounds: Continuing.

Antimicrobial Stewardship:
Plans underway to establish focus groups in Level 2 and level 3 BCH to formalise processes regarding antimicrobial stewardship in conjunction with senior medical/ nursing and pharmacy staff. If successful, this potentiall could be rolled out to other areas.

Patient Experience
Patient Experience Collaborative continues.
Professional Nursing
Staffing: **Ward 5A: (FSL: 53.06)** Current RN vacancies: 12 wte **Ward 6A: (FSL: 41.15 WTE)** Current RN Vacancies: 6.31 wte Current non RN vacancies: 6.91 wte **Ward 6B: (FSL: 38.20 WTE)** Current RN Vacancies: 3.50 wte Current non RN vacancies: 3.76 wte Support continues to be given to EMSU from staff in Ward F in the Mater and Level 2 BCH. **Ward 6C: (FSL: 42.43 WTE)** Current RN Vacancies: 6.2 wte Current non RN vacancies: 2.63 wte (Band 6 vacancy has been offered to Band 6 on the Ward) Other Areas of Concern within Surgical Division: **Ward 2E & Burns Theatres: (FSL: 26.94 WTE)** Current RN Vacancies: 5.17 wte Current non RN vacancies: 0.85 wte Maternity Leave: 0.8 wte Other: 2.0 wte – 1.0 Supernumerary status; 1.0 undertaking OH Nursing Course (Band 7 appointed on 16/01/19 outstanding Band 6 x 1.0wte Theatres to be appointed) **Ward 3 South: (FSL = 40.73)** Current RN Vacancies: 7.98 wte Current non RN vacancies: 2.52 wte Long term sickness: RN: 2.0 wte Maternity Leave: 2.0 wte **Urology Day Care: (FSL= 5.49)** Current RN Vacancies: 1.50 wte. New Band 7 appointed to post from SHSCT commencing in Feb 2 Band 5 staff redeployed from other areas. **Cardiac Theatres : (FSL = 28.03)** Current RN Vacancies: 6.0 wte Current non RN vacancies: 1.16 wte Long term sickness: RN: 1.67 wte Career breaks RN: 1.3 wte Maternity Leave: RN 2.0 wte Actions: All areas advised to fill current Band 3 and Band 2 Vacancies. Submissions made re Band 5 uplift for some areas. Review of Telefords still ongoing. ASM's requested to nominate staff to participate on rolling Band 5 interview panels Use of experienced bank staff as much as possible to supplement existing staffing.

NDL team requested to provide additional support to wards where there are particular concerns re nurse staffing. Cardiac Theatres participating in Theatres Recruitment event at the start of February Exploring the possibility of having a rotation programme within Surgery. All ASMs encouraged to have staff members on interview panels. **Incidents of Misappropriation of medication:** 3 staff investigated for misappropriation of meds. All disciplinary panels concluded 1 x RN given formal written warning – no specific recommendations from panel 1 x RN given final warning – 2 recommendations from panel which are being followed up by ASM (this staff member has appealed outcome of disciplinary) 1 HCSW dismissed

Divisional Nurse Variance Report

Divisional Nurse: Trish McKinney **Directorate: SHWH**
Service Area: TOR **Date: 15 February 2018**

Patient Quality and Safety

1. **Staffing**
    - Staffing continues to be challenging with circa 50 WTE vacancies and approx. 6% absence across the Division. Risk being managed (Beds closed when absolutely necessary and back fill more available in other areas which has allowed beds to be reopened and 3 beds uplifted in T&O).
    - Band 6 transformation recruitment exercise successful in TOR. Remaining vacancies will be advertised asap.
    - 3 band 7 ward sisters on LTS have now returned.
2. **Bed Pressures/closures**
    - All beds open in T&O (89) based on additional new staff and ability to back fill.
    - Ward 6a MPH flipped to accommodate fractures patients (20 additional fracture beds). Total fracture beds 109.
    - Increasing numbers of patients being managed in escalation beds
    - Trauma triage has expanded and is now having a positive impact on numbers attending fracture clinic.
    - Work commenting on identifying the pathways for patients who are going to attend the new MSK assessment area in the Emergency care village (planned for Winter 19/20)
3. **HCAI:**
    - Zero cases of MRSA since July 2018
    - 1 C Diff case in ward 4C managed appropriately
    - Meeting with IPCN and microbiology re: increased incidence of C Diff in ward 4B and increased GRE wound infections in ward 4A RVH.
    - Weekly reports discussed at TOR SMT huddle.
    - HCAI walk arounds continue.
4. **Documentation**
    - PACE being rolled out in orthopaedics MPH. Progress slow but very positive feedback from staff
    - Plans to roll out PACE in T&O October 2018 have now been pushed back to accommodate roll out in MPH.
    - NEWS 2 being rolled out by end March 2018
5. **IDDSI**
    - Changes to terminology starting on 11 March. Ward based training being supported.

Patient Experience

QI: QI project on reducing unnecessary urine testing pre-op in MPH.

Professional Nursing

- Focus on supervision for the final quarter of the year.
- Planning for Ward sisters away day 22 March 2019.
- Permanent Secretary visited T&O RVH on 28 January 2019
- DoN visited T&O 1st February 2019. Very positive visit.
- Attended the delegation framework launch at Malone house 31st January 2019.
- End PJ Paralysis and HCN implementation and trauma triage presented at Strategic leadership forum 13 Feb 2019 (good feedback)

Divisional Nurse Variance Report

Divisional Nurse: Paula Forrest **Directorate:** Adult and Social Primary
Service Area: OPS Inpatient areas **Date:** February 2019

Patient Quality and Safety		
CATHERINE COLLINS	**MARGARET DEVLIN**	**NATALIE MAGEE (Valencia)**
INFECTION CONTROL **Ward 1** HH = 100% PPE = 100% **Ward 2** HH = 100% PPE – 100% **STAFFING** **Ward 1** • FSL = 29.82 ASL = 24.84 • Absenteeism = 0.56 WTE –0.5% • Agency spend averaging 150 hours per week - reviewed weekly **Ward 2** • FSL = 29.33 ASL = 25.44 • Absenteeism – 4 WTE – 17% Ward 2 has no Band 6 or 7 presence. Situation discussed with Service Manager and Divisional Nurse – agreed that Sr. Taggart will transfer to Ward 2 temporarily. Two Band 6 staff currently on Ward 1 will oversee day-to-day management with weekly oversight meetings – comprised of ASM and all ward sisters. ASM is currently basing herself in Ward 2 until Sr. Taggart is in place – thereafter she will base herself in Ward 1.	• Staffing remains a risk with 22.24 WTE Band 5 vacancies across OPS (BCH & Mater). • Within BCH, this is projected to increase by 5 wte Band 5, 1.0 Band 7 & 1.0 band 6 due to recruitment outside of Service & internal transfer requests. • Vacancies in 6E/F currently at 5.5 WTE however if we increase to 35 beds we need an additional 1.66 • Work is ongoing to recruit to all posts across both services • The use of off contract agency staff is necessary to cover vacant RN shift and provide assurance. This is risk assessed daily. • There is an ongoing need for 1:1 care for patient at risks. One to one risk assessed are reviewed daily • Work is ongoing to ensure that rosters are effectively managed. • The COE Outreach service continues daily on the BCH site Monday-Friday and remains primarily a Nurse led service with assistance from OT & Physio colleagues. Performance to be measured against LOS, overall numbers of outliers in comparison to 17/18 and staff & user feedback.	**Valencia Ward** • Ward has escalated risks associated with staffing due to on-going difficulty recruiting B5 nurses (4.59 vacancies) which has been highlighted on the trust's risk register. • 2 B5 on secondment within service area • Ward is being supported by 3 agency RMNs from England • Rolling advert continues for band 5 Staff Nurses and ASM weekly liaises with BSO • Attendance management policy being strictly applied and supported by HR team • Currently 7 patients on ward at present. Advert has closed for ward manager's post and we have 3 applicants. ASM is arranging interview panel to proceed with shortlisting and agree interview dates **Dementia Inpatient and Outreach Service Improvement Group established (meeting monthly)** To undertake a review of the nursing workforce to stabilise and make recommendations on an appropriate staffing model, commensurate with the

• Agency/Bank spend remains high – last spend = w/c 28.01.19 = 365 hours. One patient requiring 1:1 at present. • MDT working group established - reviewing assessment for 1:1, management of patients requiring 1:1 and review protocol for this group. • Agency spend continues to be closely monitored. • Meeting held with Finance Team. Review highlighted the significant increase in spending between last two years with 18/19 almost 2.5 times higher than previous year. The most significant factor in explaining spend relates to patient profile. • Meeting with Divisional Nurse - to discuss situation and provide assurance that all controls are in place. Agreed to review possibility of introducing additional Band 2 staff to offset need for 1:1. **Patient Acuity Tool** Aishling Pelan has been contacted with regard to implementation of patient acuity tool – Meeting agreed for 13 March **Adjusting E Rosters** New rosters will commence on March 1	• 2wte Band 7 NDL posts to be interviewed 28.2.19 • 6 band 5 nursing posts have been uplifted to band 6 HASU nurses for the Stroke service. They commenced in post 11th February 2019. • Band 5 posts being interviewed 28th February 2019. **SEA** • SEA to be completed w/c 11.2.19 regarding patient deterioration 7N. Agency contacted to secure attendance from RN on duty. • SEA to be completed w/c 11.2.19 regarding avoidable PU BCH Direct following RCA 8.2.19 • SEA to be undertaken 27/2/19 regarding C.Diff sampling process, and incorrect labelling of specimens in 7 South. • TVN highlighted number of RCA to be undertaken 7 South regarding heel ulcers. Clinical Co-ordinator liaising with Ward & Deputy Ward Sister to clarify detail and set up SEA	needs of the patient group and the care and treatment model To develop strategies to support the recruitment, retention and development of the team To promote and enable collaborative working with service users, carers, staff and relevant stakeholders to promote the delivery of safe, person centred effective and compassionate care To work collaboratively with the nursing and wider multi-disciplinary team to promote a working environment in which staff feel connected, engaged and valued To build on the nursing skills capacity and establish formalised activity that will support and strengthen clinical care governance and deliver effective outcomes for service users and carers through: • Leadership and Accountability • Safe and Effective Practice and Care • Effective Communication and Information • Accessible, flexible and responsive services • Public and service user involvement • Effective use of resource To improve patient outcomes through the development of a culture of learning and continuous improvement To review the suitability of the current Inpatient environment, which will include scoping of other models that may deliver

		alternative safe effective assessment and treatment of behaviour disturbance associated with dementia. Produce an options paper for the sustainability of the current model and potential alternative models including relocation from Knockbracken Health Care Park Site.
Patient Experience		
Ward 1 – No new complaints **Ward 2 -** No new complaints Two outstanding complaints 1. Agency staff highlighted concerns at manual handling and staff attitude. Unable to contact the individual to complete interview. 2. Visiting OT from Valencia expressed concern at attitude conveyed by two staff nurses. In write up stage at present **Exit Questionnaires** Positive feedback on questionnaires **Refurbishment of Ward 2** Ward 2 requires significant refurbishment. This will require decant of patients to ward 3. Costings are being finalised for submission to Senior Management for consideration Preliminary Meeting on Patients safety relating to development of contractures **MDT Oversight meeting** Concerns raised by consultant regarding two patients currently in Ward 2 Meadowlands. Both patients had developed leg contractures whilst	• Interviews completed 29.1.19 for 7 Dementia Companions. 6 successful candidates following recruitment. 1 wte to be re-advertised and interviewed ASAP. • 2 active complaints for 7 South BCH involving Nursing and Medical care. Consent awaited but information has been collated to ensure prompt response. • 1 active complaint for RVH 6E/6F	Complaints –No complaints Compliments- Dentist reported – care very good, previous patients sister who was discharged over one year ago visited with biscuits/sweets for staff team, comments from visitors- “ staff are wonderful here”” this is a beautiful place” card and chocolates from deceased patients relatives, email received from social worker of patient discharged last year.

inpatients in Meadowlands Ward 2. A further patient who had subsequently discharged was also believed to have developed a leg contracture. This apparent cluster of three cases in the same ward prompted service manager to escalate the matter to both the Divisional Chair & Divisional Nurse requesting an urgent meeting of the multidisciplinary team to review situation Meeting took place on 30.09.19 - agreed that further review of cases should be undertaken. It was not considered appropriate to stop admissions. Divisional nursing and medical lead to meet again with team on March 11. **Staff Survey** What Matters To Me Staff survey distributed as precursor to Trust Values Training		
Professional Nursing		
Clinical Supervision All registrants are or will be compliant with CS standard by March 31 2019 –9 registrants still require one supervision session **SDRS** Fully compliant – all SDRS will be uploaded by Feb 12 **PACE**	• A nurse remains on precautionary suspension. Trust investigation now complete & report shared 11.2.19. Date awaited for Disciplinary panel for above. Staff member referred to NMC by BHSCT • 1 RN remains on amended duties whilst awaiting an OH appointment 14 February 2019 to confirm action plan set out is appropriate for new diagnosis of ADHD. Formal capability stage 1 can commence once appointment completed.	• A new band 5 to commence on duty on 4th, March. • Rolling advert continues for band 5 Staff Nurses and ASM weekly liaises with BSO • 2 band 5 posts have been uplifted to band 6. Planned interviews on 9th March resulted in both candidates not attending. These posts have been re-advertised. • Ward clerk is supporting mandatory training bookings; • Supervision compliance has been addressed and SDR's have been

Meadowlands staff undergoing PACE training. NOAT now undertaken each month **NOAT** Non-compliant in last quarter. Meeting with Divisional Nurse – agreed :- • Undertake NOAT each month a • Extend responsibility to Staff nurses • Introduce ward champions • Incorporate as part of March to Safety **IIP** IIP preparation completed and one staff member in ward 1 attending interview **Nurses in Difficulty: 3 members of staff** **Risk Assessment**s • Changing Profile of patients in Meadowlands – no changes to RR • MDT Assessment underway – providing a multidisciplinary perspective on Risk	• 1 RN ongoing Informal stage 1 capability due to multiple medication errors. Action plan in place, process being led by Band 7 with oversight from Clinical Coordinator. • 6E/6F 4 x RN's on long term sick. Query one retiring. 2 band 2 long-term sick query one retiring.	completed for all band 5 staff. ASM will be supervising staff until new band 7 appointed. RQIA Letter submitted to MH re concerns raised by staff during RQIA inspection. MH responded to the correspondence on 3/1/19. RQIA report with QIP. CLT unaware the it had been sent until 12/2/19

Minutes of the Trust Board Meeting
held on 3 December 2020 at 10.30 am
via Microsoft TEAMS (due to COVID-19 guidance)

Present

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr Chris Hagan	Medical Director

In Attendance:

Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Bernie Owens	Director Neurosciences, Radiology
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Gillian Traub	Interim Director Adult and Primary Care
Dr Clodagh Loughrey	Interim Director Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Ms Paula Forrest	Co-Director Nursing – For Min. 54/20a
Mr Wesley Emmett	Management Consultant - Observing
Miss Marion Moffett	Minute Taker

Apologies

Mrs Caroline Leonard	Director Surgery and Specialist Services
Mrs Bronagh Dalzell	Head of Communications

47/20 Minutes of Previous Meeting

The minutes of the confidential Trust Board meeting held on 1 October 2020 were considered subject to minor amendments.

48/20 Matters Arising

a. Questions Submitted by Stanford Smith (Min. 40/10)

Mr McNaney confirmed that the Trust response to Mr Smith's questions, tabled at the previous meeting had been shared with members as follows:

Questions asked of each Non Executive and Executive team member currently employed should you not do the honourable thing and resign given the words of the minister above? And if not why not?

Each Board member you addressed has considered their personal position since the allegations of serious abuse first came to light in 2017 and deeply regrets the serious failings in care and the inability to ensure the effective implementation of governance at Muckamore Abbey Hospital during their time in office as a member of the Board of Belfast Health and Social Care Trust. For each Director and Non Executive Director, that is a matter of profound regret. However, each Director and non Executive Director sees it as their duty to put right the wrongs of the past, work hard to implement the findings of the Muckamore Review and to participate fully in the Public Inquiry announced by the Minister.

While the Board acknowledges its failings as made clear in the Review into Leadership and Governance at Muckamore Abbey Hospital (dated August 2020), it also recognises, as highlighted by the Review, that appropriate governance procedures were in place at Muckamore Abbey Hospital and that the Board was unable to act because there was a regrettable failure to escalate serious issues to the Board. The Board fully acknowledges the Review's comment that there was a 'lack of curiosity' shown by the Board which contributed to an environment which enabled the serious maltreatment of vulnerable people to go unnoticed for so long. This is a matter of profound regret to each member of Trust Board.

Since issues of ill treatment have come to light, Trust Board has focussed its energy and commitment to ensuring that Muckamore Abbey Hospital is a safe place for our patients. It scrutinises all aspects of care in Muckamore. Since September 2017 when the Board first became aware of allegations, Trust Board has taken significant steps to assure itself that issues of historic abuse are being dealt with and that ongoing care is safe - the governance arrangements which are in place today ensure there is appropriate oversight of all aspects of care and service delivery, and that there is escalation and response to any concerns.

Trust Board continues to seek independent advice on governance from experts in Great Britain, including Margaret Flynn, Chair of a Serious Adverse Incident Review into abuse at Muackamore, and most recently, from East London Foundation Trust, one of the leading specialist mental health and learning disability Trusts in England.

Questions asked of each Non Executive and Executive team member currently employed how many times have you visited Muckamore abbey hospital?

It is important to provide some context regarding the commitment of Non-Executive Directors. As members of Trust Board each Non Executive Director has a programme of commitments which includes membership of a number of Board committees, oversight of staff, communication with the Public and media etc. as part of this the Board completes various visits across all services and departments in the Belfast Trust. Non Executive Directors fulfil their remit by providing 4 days of service per month. The Trust has a budget of £1.5 billion, employs over 22000 staff, maintains over 2000 hospital beds and provides services in over 150 sites

I can confirm that since being appointed into current positions the following visits to Muckamore Abbey Hospital have taken place.

Board Member/ Director	Visit 1	Additional Information
Peter McNaney Chairman	7 + Covid virtual visit	Safety and Quality Visits/Trust Board Workshop/Chairman's Awards/family meetings
Martin Bradley Vice-Chairman	2	Trust Board Workshop /Visit
Miriam Karp Non Executive	2	*Safety and Quality Visit, family meeting
Nuala McKeagney Non Executive	3	Trust Board B Workshop/Visits
Patrick Loughran Non Executive	1	Trust Board Workshop
Anne O'Reilly Non Executive	0	
David Jones Non Executive	0	
Gordon Smyth Non Executive	0	
Dr Cathy Jack Medical Director 2014-Jan 2020 Chief Executive Jan 2020	11 + Virtual Visits during Covid	*Safety and Quality Visits/Trust Board Workshop/Meetings
Aidan Dawson Director of Specialist Hospitals and Women's Health	1	*Safety and Quality Visit
Bernie Owens Director responsible for Muckamore Abbey Hospital	From Tuesday 29 October 2019 to June 2020	Director attended all day Tuesdays on a weekly basis and also attended ad hoc meetings
Maureen Edwards Director of Finance	2	*Safety and Quality Visit/Senior Staff Meeting
Brenda Creaney Director of Nursing	17 +	Visits/meetings/Trust Board Workshop/ Executive Team meeting/ Celebration Event/Carol Services etc. In addition, since 2017 the Director of Nursing located herself and regularly worked from Muckamore Abbey Hospital.

**Safety and Quality Visits form part of the Belfast Health Social Care Trusts safety and quality improvement agenda to support the Trust in becoming a leader in providing safe, high quality and compassionate care through developing a culture of excellence in safety and quality by engaging, inspiring and supporting the workforce to deliver improved outcomes and experience for those in our care.*

Safety and Quality Visits involve Directors (from a different area of responsibility to that of the area being visited) and Non-Executive Directors visiting both clinical and non-clinical areas to provide an informal method for leaders to talk to front line staff about patient safety, what matters to staff and service users, showcase good work, discuss what could be even better and identify key actions to be taken to improve service user safety.

Question "And how many questions did you raise at board meetings in respect of Muckamore abbey hospital?"

Since allegations of abuse came to light in August 2017 an update regarding these matters and actions to address failings at Muckamore Abbey Hospital, has been consistently included on Trust Board meeting agendas. Muckamore Abbey Hospital has featured as a regular standing item, initially in confidential session and publicly since July 2018. All public meeting minutes are available on the Trust website.

Minutes demonstrate provision of detailed information provided by the Trust management and how information has been consistently interrogated by Trust Board members with probing questions, challenge and testing of assurances provided by the management team. The Board acts collectively as a unitary body and as such, I do not believe it is necessary to specify how many times each member individually asked questions. At each meeting there has been discussion and all those staff listed in your request, have fully engaged through asking questions, providing views, advice, challenge and seeking assurances.

Apart from Muckamore Abbey Hospital, what assurances can the chief executive Dr Jack give myself and the concerned public, that there are no other incidents or concerns involving adult safeguarding at present anywhere within the trust?

The Belfast Trust provides a wide range of hospital and community services to vulnerable adults. Staff working in these services are recruited via robust Human Resource procedures and processes including checks with Access NI where relevant to their role. Staff are provided with information during their induction in relation to safeguarding and will receive further training as determined by their role and responsibilities. Professional staff involved in directly providing care also receive supervision from their line manager in accordance with their regulatory requirements. Despite these processes being in place safeguarding incidents do occur on occasions. The Trust has clear policies and procedures in place for responding to these incidents and concerns and in ensuring the immediate safety of the patient, the investigation and management of the concerns such that all necessary actions are taken, and that learning is identified and shared.

Dr Jack since your appointment as chief executive there has been a further 29 incidents of staff on patients at Muckamore abbey hospital which have been referred to the PSNI. Can you explain is Muckamore abbey hospital a safe environment for patients and is it fit for purpose?

Since the maltreatment of patients came to light in August 2017, significant lessons have already been learned and many improvements have been put in place to protect against this happening again. We now have rigorous processes to ensure the safe care of patients and we actively encourage a culture of greater openness amongst our staff and our families. Additionally, there have been many improvements to leadership and governance at Muckamore Abbey Hospital since 2017 including our work on governance with East London NHS Foundation Trust and as a result of the Serious Adverse Incident Investigation entitled, 'A Way to Go' and conducted by Margaret Flynn. We are confident that Muckamore Abbey Hospital is much safer today. Examples of improvements include:-

1. A weekly Safety Report which scrutinises incidents, including the use of physical interventions.
2. The use of seclusion and voluntary confinement is closely monitored and presented graphically to easily pick up trends. This includes not just the number of seclusions occurring but also the duration of any seclusion episode.
3. There is a weekly review of all incidents at ward level via weekly Live Governance, chaired by the Clinical Director;
4. There is also randomly selected contemporaneous CCTV viewing - all wards have CCTV viewing sampled and reviewed by an independent team on a regular basis.
5. A Safety Report is presented at each Trust Board and at the monthly Muckamore Directors Assurance meeting.

Trust Board also notes the comments by the Muckamore Review team at paragraph 8.34 " The Board members expressed their profound regret and shame for the events at MAH. The Trust Board has since made efforts across a whole range of systems to ensure the safety and wellbeing of patients. While the 2018-20 period falls outside of the Review team's terms of reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions "

b. Questions Submitted by Mrs Sandra Harris Crowther, Working Together for Learning Disability

Mr McNaney confirmed that the Trust response to Mrs Harris Crowther questions, tabled at the previous meeting had been shared with members as follows:

It is of deep regret to the Trust that families who are caring for or supporting family members with a learning disability feel abandoned by us. We take our statutory duty for involvement as laid out in the Northern Ireland Health and Social Care (Reform) Act 2009 very seriously, and fully accept that there is much room for improvement as to how we work together in the planning and provision of services for people with a learning disability. There were many families who were keen to be involved in the Belfast LD Forum and the lack of progress with this Forum from September 2019 onwards has also undoubtedly contributed to the sense of abandonment described.

We have identified a number of key steps we want to take to re-establish contact and start to rebuild our relationships so that we can move forward with our families as partners in our decision making and planning. Our first step will be to host a series of zoom joint engagement sessions with staff, families and carers across learning disability services, both hospital and community, to co-produce principles and models of good communication. These sessions will commence in November 2020.
We also plan to have a Non-Executive Director Champion for Learning Disability as a visible mark of our commitment to learning disability services. This Non-Executive Director will be supported by the Director for Learning Disability Services in taking forward a communication plan for families and carers.

I hope that this document will provide you with both information and reassurance that our desire is to see learning disability Day Centre services restored in the fullness of time, when it is safe to do so, and our desire to address a lack of proactive and meaningful engagement with our families. We look forward to engaging with you all as we do so.

- **Of the 517 service users (FOI) accessing Day centres prior to lockdown, how many are now accessing the day centre?**

Currently there are 311 service users attending the 8 Learning Disability Day Centres.

- **What was the number of service hours delivered to service users prior to lockdown and what is the level of service hours delivered now?**

Day Centre services are not traditionally calculated in service hours therefore it is unfortunately not possible to provide this figure. However, in 2019/20 there were approximately 8,850 attendances per month across Day Centres and Community Day Services. In September 2020, there were 2,162 attendances in Learning Disability Day Centres and an additional 67 attendances in Community Day Services for the two weeks they re-opened.

- **What criteria do service users have to meet to be offered a service?**

In line with the regionally agreed Learning Disability Recovery Framework developed by the HSCB in conjunction with the Trusts, family carers have been prioritised in Phase 1 and 2 of the Day Service Recovery Plan. Currently, in Belfast all service users who live at home with family carers have been offered a place back at their Day Centre. The vast majority of service users living with family members have returned since the Centres re-opened in July. However, a small number of families have been reluctant for their family member to return to the Day Centre due to concerns regarding Covid-19 and have said they would prefer to wait until restrictions have been lifted or after a vaccine is in place. Regular contact by telephone is being maintained with them should they change their mind. Additionally, activity resources

continue to be sent out and involvement with Zoom calls and some outreach activity such as walks is being maintained, where possible.

- **As of 1 October 2020, how many service users and staff are in each of our eight day centres during any 2hr session, since this seems to be the offering to service users?**

Numbers vary from day to day but on 28 October 2020 the numbers were as follow:

Centre	Service Users *	Staff**
Edgcumbe	25	19
Suffolk	17	16
Everton	18	17
Orchardville	28	19
Mount Oriel	10	6
Mica	8	6
Fallswater	5	4
Fortwilliam	9	6

***Service users'** numbers are those who actually attended on the day – across all centres there were a number who cancelled or did not attend for a variety of reasons.
****Staff numbers** include all Day Care staff including managers, deputy managers, and staff doing outreach work and working on community hub calls.

- **What are the expected, maximum number of people (staff/service users) that can be expected/ allowed in our day centres?**

Prior to re- opening, all Centres completed an environmental risk assessment. The risk assessment process included site visits where Infection Prevention Control, Health and Safety Team, a Carer Representative and Facilities Management were all invited to participate. This was an opportunity to both explain how different systems such as "social bubbles" and daily screening could work as well as agreeing on signage and location of hand sanitisers. As a result of these risk assessments, it was determined that there was a need to limit activity and footfall in order to demonstrate that social distancing could be maintained. The impact of this has been significant and some Day Centres which previously had 80+ service users attending each day are limited to less than 20 service users. The environmental risk assessments also highlighted a number of anomalies in the layout of our Day Centres, some of which were not purpose built. Some Centres have rooms leading off other rooms and infection prevention would not permit both rooms being used due to the risk posed with "through traffic", so one room had to be stood down and used for storage. The number of staff and service users varies from Centre to Centre depending on the space, level of support needs (1:1; 2:1 etc.) but initial risk assessments have been assessed as follows –

Centre	Maximum Number of Service Users per session
Fallswater	5
Mica	10
Edgcumbe	30
Everton	21
Fortwilliam	6
Mount Oriel	5
Orchardville	28
Suffolk	19

- **What are the staff to service user ratios in each centre?**

Within each Centre there will be staff who are working directly with service users attending the Centre, while there are others who are involved in outreach work with other service users and others remain involved with the community Hubs contacting families, carers and service users. Staff to service user ratio depends on assessed need, some service users require 1:1 support, others 2: 1 support and others can be supported in small groups of 3 or 4. However, there will be 2 staff in all groups in case a service user requires support for a specific individual need, which may require them to leave the room.

- **What needs to be triggered in regulations/staffing to allow more access to the day centres?**

The most significant single regulation to allow an increase in accessing the Day Centres would be a reduction in the social distancing requirements.

- **How many of the 207 full time equivalents (FOI) working in day centres prior to lockdown are back in place?**

All of the staff employed in Learning Disability Day Services prior to lockdown have returned with the exception of 3 staff who continue to work in LD Supported Living services in Rigby Close and Hanna Street.

- **If they have not yet returned to LD (Learning Disability) where are they and why are they not being used to support LD?**

See above, all bar three staff have returned and their temporary redeployment is regularly reviewed with their Manager.

- **If they cannot work in the day centres due to restrictions on social distancing what are they doing to support LD service users?**

As above.

- **What LD service provisions are being initiated for service users in supported living, residential and nursing homes who were previously accessing day centres prior to lockdown, and desperately need access now to some day activities?**

We are currently undergoing a scoping exercise regarding service users in supported living, residential and nursing homes who were previously accessing Day Centres prior to lockdown with a view to developing some form of outreach work in the various facilities. Managers are asking all staff if they would be interested in providing this in-reach work but it will have to be done in the context of regional Infection Prevention and Control guidelines regarding Trust staff entering the various facilities as well as RQIA Guidelines.

- **What oversight do you have on the number of supported living, residential & nursing homes that have implemented the latest visiting guidance for families; have an activity schedule for all service users in these residential settings; have video calling facilities and adequate hardware; regular outside reviews/inspections; adequate testing and personal protective equipment?**

All providers are currently reviewing their visiting arrangements in light of recent guidance from the Department of Health and are in contact with the Trust's Care Managers in relation to this. However, there are a number of providers seeking further guidance from the Department of Health about the proposed Care Partner model before proceeding with implementation, in light of ongoing concerns around community transmission and increasing footfall. Trust staff continue to carry out virtual reviews of service users and visit the facilities if there are any concerns by either party.

Care Homes are working hard to support activities for service users in their settings in the context of high staff absence and limitations associated with the Covid-19 pandemic. Day care in-reach is being explored for residents who would have attended Day Centres.

In addition, the Department of Health asked each Trust to scope the equipment required across Care Homes, which included pulse oximeters, non - contact thermometers, Blood Pressure monitoring sets and ipads to support virtual visiting. The list of required equipment was shared with the Department of Health and funding has been made available to support the purchase of these items.

All Care Homes are registered for routine Covid-19 screening via the Public Health Agency and provide updates to Trust to advise on outcomes; in addition all Care Homes provide a daily Covid-19 status report to the Trust. The Trust delivers PPE on a weekly basis to Homes and provides training in donning, doffing and Covid-19 testing. Infection prevention control staff from the Trust have visited facilities to provide advice on a range of issues, for example, safe disposal of PPE etc. Any concerns about inappropriate use of PPE is followed up by unannounced monitoring visits by Care Management staff.

- **What level of respite is now available for families across the city, and what are the criteria for access?**

We currently have stood down all statutory short-break beds as these beds are being used as part of the Surge Plans for the service.

Throughout the first Covid-19 surge, there was a reduction in demand for commissioned respite beds as a number of families were concerned about the risk of their loved ones contracting Covid-19. The Trust recognises that there will be an increasing need for respite in the coming months with the impact of the enduring length of the pandemic and is in discussion with providers regarding capacity.

- **How many people with learning disabilities are transitioning from schools and what provision is being made for them?**

There are eight young people with a learning disability transitioning to Day Centres. The plan is that all young people transitioning to Day Centres will start late October, early November– contact from Managers have been made with individual carers and service users that we have received completed "About You" referral document for.

- **The Department of Health statistics published for Carers Assessments shows that the Belfast Trust has carried out 432 during the period April-June 2020. Of these 432 assessments, 20 were for Learning Disability. This represents 5% of the total assessments carried out across all programmes of care but more distressingly 2% of the population of service users living with family carers. If there was ever a time that the legal right for a carer assessment should be upheld, it is now. These families need supported and a range of services or DPs for carers themselves needs to be urgently developed.**

The Trust recognises that the level of carer assessments carried out has been poor. The Social Work team in Learning Disability services are targeting this area for improvement and it is kept under constant review as the Trust has a statutory obligation to offer an assessment to any carer identified under stress. There is no specific assessment used to identified carers under stress but it is based on the knowledge that the Team and Keyworker have of the family and service user and it is also identified when additional help and support is requested through any member of the wider multi-disciplinary including day services. The figure of 20 assessments being completed is correct although a further 20 assessments were offered but declined. During the period January 2020 to September 2020, 162 carers received a carer's grant, which were used, for example, to avail of therapeutic treatments, assistance with ICT equipment during the first surge to facilitate zoom calls provided by day opportunities and zoom classes for carer activities and peer support. Carers assessments are an area that we keep under constant review. Trust staff have a statutory obligation to offer an assessment to any carer identified under stress.

- **What is the situation for the 1,055 service users not in day centres? What, if any LD service provision, education, or activity outings have been returned to them?**

Service users who are not in Day Centres are being supported in a range of ways. This varies from service user to service user, drawing upon a database which contains information on each individual drawn from community assessments and from key workers. This informed the additional support put in place by the Social Work team, which included one to one support, taking service users out for a walk, or house-sitting to allow families to fulfil errands. This service was provided by staff redeployed from Day Centres.

- **How many are accessing day opportunities (statutory/non-statutory)?**

The non-statutory organisations that we contract to provide community based day opportunities are collectively contracted to support 634 people with learning disabilities across the city – this will include service users attending Day Centres and those who do not.

- **What replacement services are now being planned to supplement this decrease in services, lack of short breaks, and especially for those restricted in supported living, residential and nursing homes with no access to daytime activities?**

All residential and nursing homes should have as part of their ongoing timetable a programme of daytime activities. However, it has been recognised that the increased numbers of residents not accessing Day Centres has put pressure on this resource. Regionally a cost pressure paper is being submitted to release funding for all of the commissioned residential and nursing homes to have additional resource for daytime activities. Within statutory day services, we have been considering how we can best support services users living within supported living, residential and supported living environments. Discussions are ongoing with RQIA as to the position of staff carrying out in-reach day activity in context of being “essential” in line with regional Care Home guidance and we are scoping numbers of staff who would consider doing in-reach work supporting service users already known to them in local residential and nursing homes.

- **What work is being done with community & voluntary sectors to increase the availability of alternative services?**

Each organisation has from the outset maintained contact with the Day Opportunities Manager in relation to alternative services they have in place and their method and process of delivery.

As a result each organisation has:

- Provided information on all alternative activities that replaced their contracted activity including any additional activity that they have undertaken
- Developed a wide range of social media platforms and their IT capacity to enable them to increase the services that they provide and offer these services to a wider audience
- Submitted a Recovery Plan detailing how they would continue to provide services and plans for a phased return to normal services where possible
- Continued to submit Monthly Monitoring Returns detailing completed activity levels in terms of types of activity, hours and service user attendances and participated in quarterly Contract Monitoring Meetings which are ongoing
- Completed Covid 19 Response Monitoring Return Forms detailing the alternative activity undertaken in both quarters and plans to restart activity aligned to their Contract
- Consistently provided updates on ongoing activity and any special activities/events which enables us to promote the service across the Trust and with each of the other organisations
- Contributed to the development of a BHSCT Day Opportunities Newsletter to promote the work of their Organisation and to increase awareness of alternative services taking place across the City which has been shared with all staff in community teams.

- **How many families have been offered SDS (Self Directed Support) or a personal budget to be used to support families and stimulate other community-based activities?**

Currently there are 360 service users in receipt of self-directed support. One hundred of these were offered and arranged during the first Covid-19 surge. All packages were reviewed and additional support offered as appropriate for service users and families

- **What flexibility has been extended to families & service users on Direct Payments to use these creatively? How can the social workers be empowered to quickly respond to needs?**

All requests for self-directed payments are reviewed by the Senior Management Team within Learning Disability services. This usually occurs on a monthly basis. However during the first Covid-19 surge, requests were reviewed and approved by an Operational Manager within 1 working day.

As appropriate additionality to Direct Payments were given to enable service users to have increased hours to provide support as they deemed necessary to replace provision of day care services which were suspended.

- **Has an overview been developed of how the human rights of people with learning disabilities and their families are being impacted and an action plan prepared to address?**

The Human Rights of people with a learning disability is pivotal in all decision making taken by the staff within the service. It should be noted that a number of constraints which were placed on the provision of service were as a result of the Covid-19 pandemic.

- **How many people with a learning disability have died during this period with or without COVID-19? (How does this compare with the same period last year?)**

Since the beginning of the pandemic, there have been 4 deaths of our service users directly attributed to Covid-19. The table below identified the number of deaths of learning disability service users known to the Belfast Trust - this includes the four Covid-19 related deaths:

Usually place of residence	1.1.19 – 30.09.19	1.1.20 – 30.09.20
Nursing Placement	12	15
Residential	<5	<5
Supported Living	0	<5
Own Home	6	<5

- **What is the present level of ‘unmet’ need based on assessments for service users and family carers?**

As a result of Covid-19 the main areas of unmet need are due to the reduction in Day Care services and short breaks. Staff in the Community Learning Disability Teams and Day Services continue to support service users and carers at least weekly through practical and emotional support. Staff have also made carers aware of psychological supports that they can avail of through the Trust. Teams will escalate any concerns regarding unmet need, and the impact that this has on family carers and service users. Standalone Short Breaks beds which have been stood down are being used to support families in crisis.

- **Has this been escalated to the Health Board and Department of Health for extra resources?**

The biggest challenge facing learning disability services is the workforce to support the range of services required to be delivered. There is regular dialogue between the Trust, the Health and Social Care Board and the Department of Health

- **Is the COVID-19 Pandemic being used to permanently eradicate vital services for service users and to deliver on the objectives above?**

This is absolutely not the case. The Trust is seeking to incrementally rebuild services within the context of the Covid-19 pandemic. As has been described above, it is proving challenging for a range of genuine reasons to fully re-instate all services but it remains the Trust’s intention to achieve full restoration, rather than eradication, of these vital services.

- **Has the Belfast Trust the intention to reassess the needs of everyone who previously had a day centre place?**

The Trust has no plan to specifically reassess the needs of everyone who previously had a day centre placement. On an ongoing basis service users attending the Day Centres are reviewed and changing needs re-assessed and naturally all service users have an annual review.

- **What is the Belfast Trust's definition of 'complex' needs?**

  The Community Learning Disability Teams would use the CQC definition of Complex Care as meaning "care for people with multiple and sometimes interconnected health, communication and social needs whose care typically requires coordination and input from a range of skilled professionals"

- **When will this begin and what advocacy will be available for service users and families through this process to make sure previous assessed needs are not denied?**

Individual service user keyworkers will advocate in their best interest on an ongoing basis. In addition to this, advocacy services are sourced as necessary through Bryson House independent advocacy service to ensure that previous assessed needs are supported.

- **Are zoom services the new innovative day opportunities for our service users? Is this the quality of life they deserve?**

Zoom sessions have been only one aspect of the activities delivered during lockdown. We have established four Community Hubs along geographic patches and aligned to our Community Learning Disability Teams. Their role has been to maintain daily telephone contact with families and service users, assist with activities and offer support. By the end of July, over 11,000 telephone contacts had been made with families and service users. To ensure timely and effective communication a daily report was sent by the Hubs to the Community LD Teams flagging any concerns where stressors were appearing. This proved a very effective and positive initiative welcomed by all involved.

Over 250 Hospital Passports were updated to ensure that up to date information was readily available should any service users be admitted to hospital. By the end of July, over 1,000 resource packs had been delivered to family homes to provide alternative activities for service users. Additionally, staff from the Centres provided a sitting service for families either enabling family carers to go shopping or collect prescriptions or allowing the staff member pick up whatever was needed. Alongside this a number of Day Centre staff were aligned to the Community LD Teams and allocated service users who lived alone to regularly call to at home to provide support with meal preparation and other domestic tasks.

As lockdown eased, we provided over 500 bus runs for service users to provide a welcome break for families and a pleasant activity for service users. Many of our Centres developed fortnightly or monthly newsletters which had quizzes, picture colouring competitions, jokes, birthday details etc. to keep people in touch with their centres and what both staff and service users were doing during lockdown and these proved very popular. Additionally, centres became very proficient in their use of IT and Zoom classes in Fitness, Cookery and Gardening as well as Zoom coffee chats became the norm.

Extensive work was also done in sharing Easy Read information with families on Covid-19 and the associated restrictions, including PPE and social distancing to support them in explaining what was happening to our service users. The effectiveness of this has really become apparent since our Day Centres re-opened and we can appreciate the high level of understanding and adherence to the rules amongst our service users about PPE, hand washing and social distancing.

- **A recent FOI asked each Trust across the region to provide the dependency levels of service users. Many Trusts including the Belfast Trust were unable to provide this information.**

There is no specific tool or standardised assessment available which identifies the dependency levels of service users in a consistent and comparable way. A range of professional assessments including social work, occupational therapy, psychiatry, nursing, speech and language therapy are collated and through a multi-disciplinary discussion, the agreed dependency level of service users and their support needs are identified. We agree that there is a need to further develop and invest in services in the community so that we can ensure that 'unmet' needs is able to be fully resourced.

49/20 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

b. Questions Submitted

Mr McNaney outlined the following questions submitted by members of the public:

i. Mark Lambe, CBR NI

<u>**Finance**</u>

1. How much money has been spent on providing non-commissioned abortion services since April 2020?
2. What is the breakdown of the spending on non-commissioned abortion services
3. Where has the money been sourced from to pay for these services?

Governance

4. Has the provision of non-commissioned abortion services been approved at a Board level? If so when and please provide the minutes of that meeting.

Staffing

5. How many staff are engaged in providing non-commissioned abortion services and what has been the total cost of staffing, resources and facilities since April 2020?
6. Given that abortion is a non commissioned service it presumably falls outside the contracts of the staff involved. Are staff being paid by the trust for the time that they spend providing abortions?
7. Does the trust's insurance cover the staff providing non-commissioned services on trust premises?

Facilities

8. Many people who are opposed to abortion feel that they cannot, in good conscience, work at, or attend as a patient, any facility in which abortions are taking place. Please provide a list of all hospitals in the trust who are not providing abortions so that we can inform people of facilities that are ethically acceptable to use.

Abortion provision

9. How many abortions in the trust have been designated as Termination of Pregnancy for Fetal Abnormality since April 2020?
10. How many of these abortions have involved the use of foeticide?
11. In how many of these abortions has the child been born alive and left to die after birth?

ii. Stanford Smith

As the board will know there are seven principles under the code of conduct and accountability.
"Holders of public office are accountable for their decisions and actions to the PUBLIC and must submit themselves to whatever scrutiny is appropriate to their office."

1. Does the Chairman accept the public still have a right to hold any board member to account especially surrounding Muckamore abbey hospital? If the chairman accepts this could explain the comments made by the FOI manager?
2. As of the twenty fifth of November what percentage of the trust's workforce is off sick or self-isolating?

The Nightingale hospital.

3. How many wards are there in total and how many wards are not in use at present?
4. How many fully trained ICU nurses are the trust short at present?

5. Given the pressures of Covid-19 what assurances can the board give the public that cancer services and in particular mental health services will be protected?
6. Following on from that question if the trust can't protect those services due to staffing shortages, would or has the board asked the health minister for military support?

Members noted the submissions and Mr McNaney asked Ms Cairns to co-ordinate written responses for his approval, copies of which will be shared with Trust Board members.

50/20 Chief Executive's Report

a. Covid-19 Update

Mr Hagan presented an update report in respect of Covid-19

b. Non Executive Director Lead for Learning Disability

Mr McNaney thanked Ms O'Reilly for taking on the role of Non Executive Director Lead for Learning Disability.

51/20 Chief Executive's Report

a. Covid-19 Update

Dr Jack provided an update in respect of the current Covid-19 Surge 3 position. She explained the number of Covid in-patients currently being cared for surpassed the earlier surges. Despite this the Trust is continuing elective and critical surgery, at a reduced level, as staff are redeployed to care for Covid patients. Out-patient reviews both face to face and virtual have been maintained to date, however this will continue to be closely monitored. In the community the Trust is providing mutual aid support to a small number of nursing homes.

b. Muckamore Abbey Hospital

Ms Traub provided an update in respect of Muckamore Abbey Hospital, there are 47 patients and 3 patients on trial resettlement. There are 68 members of nursing staff who are on precautionary suspension. The total number of staff who have been arrested associated with Muckamore Abbey Hospital is now 15.

Mr McNaney noted RQIA had undertaken an unannounced inspection of the hospital. Ms Traub advised a meeting was scheduled with RQIA on 11 December to receive feedback.

Professor Bradley welcomed the commencement of the disciplinary hearings.

Dr Jack advised she had written to the PSNI regarding the second tranche of disciplinary cases.

Ms O'Reilly welcomed the progress with family engagement.

c. Neurology Inquiry

Mrs Owens advised the DOH had not yet determined a date for the publication of the Outcomes 2 Report.

Members noted the Royal College of Physicians are undertaking the external validation of the Trust's own review of the records of patients who had a Blood Patch, and whose records have not already been considered in the course of the recall or other processes.

Mr McNaney noted the Trust is starting to make preparations for the Public Inquiry announced by the Minister on 24 November.

d. Outpatient Modernisation – Update

Mr Dawson and Ms Stoops gave a detailed presentation on the Outpatient Modernisation project to address waiting lists and roll out of virtual consultations.

In response to a question from Dr Loughran, Ms Stoops advised Microsoft are supporting the development of virtual video consultations. They are also considering further digital solutions. Consideration is also being given to developing booking apps which will allow people to book their own appointment at a time that suits them and the clinician; exploring systems that would assist with validation and prioritisation of patients must at risk and getting service user feedback.

Mr Dawson advised he will provide a further update on outcomes and progress in respect of reducing waiting lists to a future meeting of Trust Board.

Dr Jack explained the overarching aim of the project is to look at how do we create capacity to ensure people can be seen in a timely way and consider if people need to come into a clinic setting or can they be reviewed virtually.

Mr McNaney asked if service user feedback was received in respect of the service change. Mr Dawson advised that PPI from patients and Primary Care colleagues is included in all aspects of the work.

Mr Dawson referred to learning from Covid in the Child and Adolescent Mental Health Service, the use of virtual clinics received positive feedback from the young service users and created capacity to see more patients.

Mr McNaney commended the work to date and acknowledged the change management approach needed to deliver services in a different way which is safer for patients. He requested that further thought be given to prioritising some of the workstreams and that further focus be given to articulating short, medium and long term objectives for the work.

52/20 Safety and Quality

a. Children's Residential Child Care Services Report 2019/20

Mrs Diffin presented the annual report of the Residential Child Care Services for the period 2019/20. She explained the report provided information in respect of the 9 children's homes for the period. However Donard House a regional facility has since closed.

Members noted the following achievements:

- All residential staff receive Trauma Informed Practice training
- The establishment of the Developing Opportunities Outcomes Response Services (DOORS) with 25 young people from the children's homes engaging in diversionary activities
- Range of Staff Health and Wellbeing Strategies led by clinical psychologists
- The Missing From Care (MFC) Strategic Partnership with PSNI, with an 18% reduction in MFC incidents in the reporting year
- Parenting and Adolescent Community Support Service (PACSS) supported 45 young people from admission into residential care and successfully continue to live with family or carers.
- Quality Improvement projects, ranging from increased participation at young peoples safety huddle, de-escalation debriefing processes of staff and timely support to staff after high level incidents
- Signs of Safety training for staff from each children's home
- Regional Social Work Awards – Residential Services won and were runners up finalists in 2 Social Work Awards and 2 Chairman's Awards
- The PACSS Team won the Social Work Team of the year award
- 444 Antrim Road Children Home Team were finalist in the Social Work Award for Learning and Development re the "My Story?" assessment
- The Chairman's Awards – 'Whoa' Award : Manager in UASC Residential Home for commitment to service to young people in residential care. 'Dare to Win' programme, a collaborative project between BHSCT, the PSNI and IFA, were runners up in the Strategy and Partnership.

Mrs Diffin highlighted the following challenges in respect of children's residential services.

- Influx of 33 UASC young people, consequential resource pressures on the residential system.

- Increasing number of young people requiring residential care (increased LAC and pressures within fostering availability) with multiple complexities (Substance Abuse, CSE, MFC, self-harming behaviours etc.).
- Increasing number of younger children requiring residential care (8-12yr), at times experiencing numerous placements and presenting with complex needs.

- Young people who present with high levels of polysubstance use and related risks. MFC / CSE, Safety Planning and teams managing the competing needs and presenting risks of young people.
- The need for adequately funded staffing levels, with particular regard to the funding of night care attendants.
- Vacancy control in response to the redeployment of the Donard Team and the subsequent impact on the recruitment of staff for the residential service and across the CCS Directorate.
- Glenmona Development: Managing the potential safety risks for the resident young people, the staff and members of the community, linked to the onsite vandalism and the arson incident in relation to Aisling House.

b. Children with Disabilities Residential Services Annual Report 2019/20

Mrs Diffin presented the annual report of the Children with Disabilities Residential Services for the period 2019/20. The report contained details of the 3 residential facilities.

Members noted the following achievements:

- During Covid staff continued to offer vital services to very vulnerable and complex children requiring full time residential placements
- Positive Behavioural Support model has been embedded in the service
- Multidisciplinary work is excellent
- Service Users feedback is very positive
- Practice Developments -staff have begun to develop practice centred on Trauma Informed Care and Signs of Safety
- Inspections – RQIA inspections have generally been positive

The following challenges were highlighted:

- Capacity - there is not enough residential capacity to meet the assessed needs of children – short breaks and long term care
- Staffing - there are a number of staff vacancies at a leadership level that need to be filled
- Legal - the Trust is responding to a number of Judicial Reviews in relation to the lack of provision
- Mental Capacity Act - There are outstanding DOLs to be completed
- Regional Strategy - there is an overwhelming need to develop a comprehensive regional strategy for children with a disability from Early Intervention to Children in Care

Mrs Diffin advised the Trust continues to liaise with the HSCB regarding the need for Children with Disabilities to pursue the capital bid to develop a new residential facility; and a strategy for Children with Disabilities from Early Intervention to Residential Care.

c. Adoption Services Annual Report 2019/20

Mrs Diffin presented the annual report of the Adoption Services for the period 2019/20. She highlighted the following achievements:

- 25 Children adopted from care, 8% increase on previous year.
- Expansion of and direct delivery of therapeutic support services to adopters and children.
- Development of a Peer Support Service for children and adoptive parents.
- Ongoing development of Post Adoption Services providing help, guidance, support, advice and early intervention service.
- Participation in a collaborative regional recruitment campaign specifically for more complex placements; sibling groups and older children (October 2019) resulting in assessment of 8 potential adopters.
- Launch of the central HSC Adoption and Foster Care Service as a single regional recruitment agency in February 2020.

Members noted the following challenges:

- Awaiting the legislative approval for the Adoption and Children's Bill – delayed by last year's Assembly suspension
- Development of services and post adoption supports through Transformational funding in preparation for the impending Bill.
- Allocation of assessments to minimise waiting times has been challenging, leading to some additional funding being allocated for this incoming year.

d. Regional Emergency Social Work Services Annual Report 2019/20

Mrs Diffin presented the annual report of the Regional Emergency Social Care Service for the period 2019/20, highlighting the following achievements:

- Modernising call handing – all calls into the service placed on PARIS – Improved recording of inappropriate calls and management of service user data.
- Introduction of new staff rota November 2019 as a pilot - improving health and wellbeing of staff - Reduction in staff working unplanned overtime by over 50%.
- Emergency Homelessness – Transitioned to the NI Housing Executive in January 2020.
- Health and wellbeing of staff - improvements in accommodation to support staff working shifts, break-out rooms, showers, standing desks, drinking water fountains, noise cancelling headsets, and seminars on sleep and diet for shift workers

Members noted the following challenges/risks:

- IT infrastructure – moving to stable platforms on all sites and reviewing the current SLA for out of hours support.

- Demands on other services –GP Out of hours/PSNI/NIAS are impacting on RESWS staff ability resolve cases in a timely manner. This is particularly the case for ASW assessments, and children requiring placements.
- There is a lack of emergency placements regionally for children who require admission to care out of hours.
- Impact of Covid on our workforce- home based working and limiting opportunities for both formal and informal debriefing
- Supporting our frontline staff and developing a culture of Trauma informed care. (2 projects underway- call-handling/social work staff)

e. Corporate Parenting Report – April to September 2020

Mrs Diffin presented the Data 10 Corporate Parenting report for the period 1 April to 30 September 2020:

Members noted the following:

- 3528 Children in Need, 3497 referred for an assessment of need
- 732 children with a disability
- 105 Young Carers
- 165 Sponsored Day Care places
- 316 children on Child Protection register (126 registrants within reporting period and 61 re-registions)
- 881 Looked After Children
- 55 places are available in the Trust Statutory 9 mainstream residential facilities
- 3 place in the Long term Children With Disabilities facility
- 10 respite placements
- 2 voluntary placements and one private placement.
- 529 Foster carers
- 580 places
- All Looked After Children had an allocated Social Worker at the end of the reporting period.
- 6 children did not have their monthly statutory visits, due to change over in Social workers. Measures were put in place to complete outstanding visits.
- 505 Looked After Children reviews were held in reporting period
- 441 were outside of the time frames required explanations and mitigations were provided for all of these. The impact of the COVID restrictions has had an impact, transfer of Social Worker or Social Worker sick leave contributed.
- 373 young people are subject to the Leaving Care Act provisions.
- 63 young people are waiting for a Personal Advisor – an improvement since last reporting period.
  Factors influencing the allocation of a personal advisor include, the increase in the number of looked after children, late entrants into care and the unaccompanied minors.
- 3 Pathway plans were not completed this was due to handover issues and allocation of new SW plans are in place to complete these.

- Leaving and After Care – 3 young people cautioned; 13 formally remanded; 11 convicted; 84 have a disability; 26 are parents; 22 are lone parents; 50 are receiving treatment for mental health issues; sadly 2 young people have died
- 529 Foster Carers; 580 places; 35 vacant places; 56 households with no child placed at period end; 87 annual reviews outstanding planned to be completed by end of November 2020; 74 Viability visits undertaken; and
- 35 Regional enquires received by the Trust
- Adoption – 23 enquires (9 from central website, 4 from specific local campaign); 16 have been waiting between 6- 12months from initial inquiry to commencement of training; and 33 domestic applications for assessment received by the Trust
- Early Years – 18,208 placements; 330 outstanding Inspections reporting period due to the COVID regulations as inspections were stood down in March 2020; there are number of outstanding registrations

Mrs Diffin explained the report provides assurance on the activities required in each of the areas of delegated statutory functions. Plans are in place to deal with areas of non-compliance which have been noted. Areas which remain a challenge for the Trust are the number of available Foster and residential placements for children coming into care, to enable matching and choice to meet children's needs.

Ms O'Reilly advised the senior leadership teams had presented all the reports in detail to the Social Care Committee. She reflected on the workforce issues across all services, particularly residential care for children with disabilities and the need for a regional approach.

Professor Bradley expressed concern at a recent media story raised by a member of staff regarding food poverty. Mrs Diffin advised that the Family Support Hubs, supported by the Trust, involving the community, voluntary and statutory sectors, including Belfast City Council were providing support such as food parcels to families.

Mr McNaney acknowledged he workforce issues reflected in the reports and proposed there would be merit in liaising with the NI Social Care Council as they were undertaking work in this area. Mrs Diffin undertook to follow up with NISCC and bring a report back to Trust Board in due course.

Following detailed consideration members approved all reports presented by Mrs Diffin.

e. Quality Management System Report

Ms Stoops presented the Quality management System (QMS) report which provided an update on activity in respect of Covid, the Phase 3 Rebuild Plans and 6 Quality Parameters i.e. safety; experience; effectiveness; timeliness; efficiency and equality.

Ms Stoops explained the QMS reporting structure and sought members views.

Professor Bradley welcomed the new QMS reporting and referenced the need for Trust Board to be advised of the concerns risks being managed in the organisation.

Ms Stoops explained going forward the intention would be for each Director to give an overview of their Divisions and report on their top 3 risks and how they are being managed.
Dr Loughran commended the non Covid work continuing in the Trust despite the public perception that only Covid services are being provided.

Following comments from Non Executive Directors Ms Stoops undertook to review the format of the reports as it is currently difficult to read due to the size of the print.

53/20 Resources

a. Finance Report

Mrs Edward presented the finance report for the period ending October 2020. She explained current end of year projections indicate a breakeven or possible small, which is similar to other Trusts due to Covid and downturn in services.

Members noted the report.

b. Major Capital Schemes

Mrs Edward advised that RICU had moved into the Critical Care building on the RVH site on 25 November. Following external infection control testing it is planned to begin transferring Theatre Services in mid-December.

c. Scheme of Delegation

Mrs Edwards presented the Scheme of Delegation which had been updated to reflect the revised EU threshold for procurement which came into effect on 1 January 2020.

Members approved the revised Scheme of Delegation.

d. Property Asset Management Plan

Mrs Edwards presented the Property Asset Management Plan (PAMP) for the period 2020/21 – 2024/25. She explained the PAMP provides an update in respect of the Trust property portfolio
.
Following consideration members approved the PAMP for submission to the DoH.

e. Business Case – New Regional Haematology Treatment Ward

Mrs Edwards sought approval for Outline Business Case (OBC) to the Department of Health (DOH) for the establishment of a new inpatient facility to provide specialist Haematology treatment. She explained there are long-standing issues with the current clinical environment necessitating significant refurbishment and expansion of the facility to improve patient safety and service user experience.

Mrs Edwards explained the OBC had been submitted to DoH, subject to Trust Board approval.

Following consideration members approved the OBC.

54/20 Audit Committee

Mr Smyth presented the minutes of the Audit Committee meeting of 30 June 2020, together with the annual Self-Assessment of Effectiveness Report

Members noted the content of the minutes and report.

55/20 Social Care Committee

Ms O'Reilly presented the minutes of Social Care Committee meetings held on 18 and 26 June and 29 September 2020.

Members noted the minutes.

56/20 Assurance Committee

Mr McNaney presented the minutes of the Assurance Committee meeting held on 28 July 2020.

Members noted the minutes

57/20 Any Other Business

a. Trust Board Business

Mr McNaney reflected on the need to review the format of Trust Board meetings to ensure appropriate time is given to reviewing progress on priority issues and ensuring the time available for meetings is most productively spent. It was agreed he would discuss the matter Dr Jack.

58/20 Date of Next Meeting

Members noted the next public meeting of Trust Board was scheduled for 4 February 2021.

Executive Team Meeting
Wednesday, 26 June 2019 at 3.30pm
Boardroom, A Floor, Belfast City Hospital

Present: Mr Martin Dillon, Chief Executive
Dr Cathy Jack, Deputy Chief Executive/Medical Director
Mrs Maureen Edwards, Director of Finance, Estates & Capital Development
Mrs Marie Heaney, Director Adult Social and Primary Care
Mrs Jacqui Kennedy, Director of Human Resource/Organisational Development
Mrs Carol Diffin, Director of Children's and Community Services
Mrs Bernie Owens, Director of Unscheduled and Acute Care
Mrs Caroline Leonard, Director of Surgery and Specialist Services
Mrs Charlene Stoops, Director of Performance, Planning & Informatics
Mrs Bronagh Dalzell, Head of Communications
Ms Claire Cairns, Head of Office
Miss Irene Thompson, Co-Director, Nursing & User Experience
Mrs Moira Mannion, Co-Director, Nursing & User Experience
Mrs Moira Kearney, Co-Director, Specialist Hospital and Women's Health

In Attendance: Mrs Joan Peden, Co-Director of Human Resources
Mr Brendan McConaghy, Organisational Development and Change Manager, Human Resources
Angela Young, Trust HQ

1 Apologies:

Miss Brenda Creaney, Director of Nursing & User Experience
Mr Aidan Dawson, Director Specialist Hospitals & Women's Health

2 Minutes / Actions Log – 12 June 2019

The Minutes of the previous Meeting were approved.

3 Chief Executive Update

3.1 TIG Update

There was no update from TIG.

3.2 East London Foundation Trust – Letter from Richard Pengelly

The letter from Richard Pengelly, dated 24 June, confirmed that the Department welcomed the planned visit by a team from East London Foundation Trust to Muckamore Abbey Hospital as it was important to provide an external perspective on the current practice. M Heaney agreed to facilitate engagement with DoH officials in line with the DoH request.

3.3 Serious Adverse Incident Report Status (Roberts)

C Jack reported that she would respond to the query from the DoH.

M Dillon reported, for noting, that the Coroner had reported on Friday, 21 June on the cause of death, following the fresh inquest into the death of Claire Roberts. The Trust will study the findings in line with normal process the purpose of identifying any further learning.

3.4 Publication of Report re the first cohort re Dr M Watt caseload

M Dillon reported that the Department had agreed to postpone the Trust's publication of the outcomes Report in relation to review of patients in Cohort 1 on foot of an unforeseen circumstance which had arisen.

3.5 Annual Quality Reports 18/19 (SAIs per Directorate and Learning)

C Jack reported that B Godfrey had written to the Trust requesting standard wording in SAIs and that they be demonstrated by directorates. There was concern regarding this as it would neither capture the entire incident nor provide for follow up learning. C Cairns participates on the SAI Group and indicated that it was not expected that there would be a request for individual SAI cases.

4 QI Presentation

Presentation by Joan Peden and Brendan McConaghy re Understanding our Culture

J Peden presented information on organisation culture, which included barriers to positive culture, outcomes and organisational actions, areas of development etc. The work was aligned with the work of Mike West, which was based on six cultural elements, and the NHS Improvement Framework. The ethos of the presentation was 'Leadership behaviour drives culture which drives performance'.

B McConaghy presented the outcomes of the diagnostic tool and staff survey. The results were itemised under headings: leadership behaviour, qualitative responses (90 pages of responses were recorded) and the data was analysed under three questions, which underpinned the five main cultural elements (ie Vision and Values, Goals and Performance, Support and Compassion, Learning and Innovation and Teamwork) and Collective Leadership. Directors were encouraged to read the qualitative feedback comments. There was no single prevailing culture in the Trust and the leadership model was more individual based as opposed to collective. The culture dashboard will be updated with the staff survey at directorate level. There were a number of recommendations based on the analysis, which related to Values and Behaviours; holding people to account, Communication and Staff Appraisals (non-medical). The suggested improvements referred to; a more co-ordinated approach to staff appraisal and engagement, clarity regarding workforce plans and how the Trust plans to meet the supply in the next number of years. The area of team working scored well and there were positive comments regarding learning and development. The conclusion focussed on three aims for improvement in the areas of Value and Vision, Goals and Performance, Support and Compassion. The Culture Driver diagram was presented and against each element, there were actions to be taken. The results of the survey will be shared with staff and the Trust Board Workshop.

J Kennedy reported from the TJNCF meeting and indicated there were workforce challenges regarding recruitment.

It was indicated that a number of staff do not have email addresses; this would need to be actioned.

M Dillon thanked J Peden and B McConaghy for an excellent presentation and indicated that this was the right thing to do as the information would provide for a baseline and reference point for the development of an action plan, which would demonstrate visible improvements.

A significant number of people were involved in the project and various methodologies were utilised; the HR team involved was commended for the excellent piece of work. K Stewart had commented on the significant amount of data that was captured and the scale of the analysis.

5 Safety, Quality, Experience – checking across the Organisation

5.1 Muckamore Abbey Hospital SITREP Report

The SITREP report was reviewed. There were positive messages and all restrictive practices were well within the working practice. The major challenge currently was securing discharge into the community; there were 3 discharges this week. C Jack reported that the CCTV showed evidence of good practice and the audit results were 100%; the vast majority had activity plans and will be reported on in the future. More work will be done with the Nursing Team regarding moral. The Trust will have access to the CCTV following the PSNI interviews. This will be reported at the Trust Board Workshop.

5.2 Infected Blood Inquiry

C Leonard reported that one of the five request's deadline is 26 June and this is currently being finalised. Rule 9 relates to securing medical records. The subject access request had been viewed very negatively by the inquiry.

5.3 Live Governance Report

(a) Corporate

C Cairns reported there were three incidents, within a 3-week period, which related to allergies and involved penicillin; all occurred in different directorates. The reason for the incidents was the significant backlog of prescriptions. The Medical and Safety Group have produced a safety lanyard as a follow up action. C Cairns will circulate this to the Team.

(b) Principal Risk

C Jack had spoken to A Dawson regarding the Audit. Previously the results of the audit were 100%, however when the independent auditors had undertaken the audit the results were 80%. A Dawson will check this as the Trust has no access to the audit. The audit requires to be updated. K Devenney was following up on this.

5.4 HCAI Update

The HCAI Update was circulated before the meeting. The current figures (outturn) for C Diff was 36 and MRSA bacteraemia was 8. I Thompson reported that all work was being done to prevent recurrence. I Thompson reported on an HCAI event, which was attended by Nursing, AHPs, Microbiology, Estates Services and 1 medical consultant. The programme items were RCAs, Antimicrobial stewardship, audit from microbiology. There was discussion regarding staff training and it was understood that the HCAI had been added to undergraduate training. I Thompson will check if this remains the situation.

5.5 MHRA Inspection of Radiopharmaceuticals

B Owens reported on the inspection. Plans had been submitted for the replacement of buildings, however, in the interim, it was necessary to modify some aspects of the building. All modifications were manageable.

6 Service Delivery – By exception – key risks needing escalation (CPD Areas)

6.1 Winter Pressures Situation Report

B Owens reported the pressures in Unscheduled Care were continuing with high numbers attending the EDs. There were some gaps in medical rotas in both ED and CAU. The waiting times overnight were increasing which results in high numbers the following day.

6.2 DSS Shared Services Programme Board Meeting

C Stoops had circulated the information to Directors before the meeting.

6.3 Specialist Doctor Rota – Mater Anaesthesia and Critical Care Rota

B Owens reported that this issue had been on the Risk Register but was removed when the specialty doctors were recruited. The consultants who cover the gaps in the service do not want payment and have requested time off in lieu. It was expected that this would have an impact on the service. Given the service is on the Mater site and was intended to become an Elective Care Centre; the Trust needs to do everything to ensure the service is delivered. C Jack, B Owens and C Stoops had met with Bishop Treanor and members of the Mater Consultative Committee and highlighted the issue. C Stoops will draft a paper to outline the situation.

6.4 Kingston NHS Foundation Trust – Proposal for Theatre Nurses

B Owens reported on the proposal for theatre nurses and discussed the costs of the proposal. It is anticipated that this contract would provide an additional 10 theatre sessions. The contract will be offered until March 2020. The situation would be reviewed on a 6 monthly basis.

7 Strategy and Partnerships (ND2, Strategic Boards feedback) monthly

8 People and Culture

8.1 Media / PR Update

There was no media/PR update.

8.2 Discovery Phase Culture Report and Summary – see item 4

9 Resources

9.1 Finance Update

There was no finance update.

9.2 Transformation Projects Update (standing item)

C Stoops advised that going into 2020/21, 21 schemes could be stood down from 31 March 2020 but the FYE costs of the remaining 64 schemes would be £15.7m with no recurring funding identified at present.

There were 85 projects, all of which required revenue to be submitted by Friday, 21 June. 72 had been submitted; however, there are 9 being held with the business case to follow. There was no allocation for 12 schemes totalling £900k. These have been completed, based on what we feel we need but – at risk of shortfall. Regarding the funding allocation, there was £805k deficit, which was mostly in Cancer Services. This had been discussed with C Leonard. There was a shortfall of £200k approx in MOH service. A new IPT for CYE had been requested which was £323k investment for oncology service transformation project, against a FYE requirement of £970k. In total, the FYE for cancer schemes going into 2020/21 would be the region of £2.5m, which was unfunded. The confirmation of the allocation to the Trust was expected on 28 June.

C Leonard said there are items that appeared on the transformation list that should have been on the services list. The funding was causing concern and the issue was raised at oncology transformation; M Dillon advised he would raise the issue at TIG.

10 Any Other Business

- **Independent Regional Review**

I Thompson reported regarding the suggested independent regional review was being considered. G Waldron was liaising with the PHA.

- **Kidney Transplantation – MOU with Beaumont Hospital Dublin**

C Leonard referred to the Action Log – item 6.4 of 12 June – Kidney Transplantation. MoU with Beaumont Hospital Dublin. C Leonard reported the meeting was productive, however concern was expressed but HSCB was happy to support this initiative. All cases would be discussed on individual merits. C Leonard had presented the work-based scenario, which included 1 or 2 lists per year within the context of the renal programme; it would be an ad hoc arrangement when matches are found. Some concerns were expressed. B Owens to provide data on the use of the renal lists by other specialties for the last 15 months to establish what work would be displaced by this proposal, if it were to proceed.

- **Trust Healthcare Science Leads**

C Jack reported that the Prof I Young asked if there could be a nomination for a science lead. A Dawson to advise he is content for this to proceed.

11 Date of Next Meeting

Wednesday, 3 July at 1.30 pm in the Boardroom, A Floor, Belfast City Hospital

Minutes of the Executive Team (ET) meeting
held on 31 July 2019 at 1.30 pm
Boardroom, Trust Headquarters, BCH

Present:

Mr Martin Dillon, Chief Executive – Chair
Dr Cathy Jack, Deputy Chief Executive/Medical Director
Miss Brenda Creaney, Director of Nursing and User Experience
Mrs Carol Diffin, Director Children's Community Services
Mrs Maureen Edwards, Director Finance, Estates and Capital Development
Mrs Bernie Owens, Director Unscheduled and Acute Care
Ms Charlene Stoops, Director Performance, Planning and Informatics
Mrs Bronagh Dalzell, Head of Communication

In Attendance:

Mr Stephen Boyd, Co-Director – *Deputising for Mrs Leonard*
Mrs Julie Mulligan, Co-Director – *Deputising for Mr Dawson*
Mr Alistair Graham, Consultant, Thoracic /Cardiac Surgery
Dr Graham McNeilly, Consultant, Thoracic /Cardiac Surgery
Miss Marion Moffett, Executive Assistant, Minute Taker

Apologies:

Mr Aidan Dawson, Director Specialist Hospitals and Women's Health
Mrs Marie Heaney, Director Adult Social and Primary Care
Mrs Jacqui Kennedy, Director Human Resources/Organisational Development
Mrs Caroline Leonard, Director Surgery and Specialist Services
Ms Claire Cairns, Head of Office

Mr Dillon also thanked Mr Boyd and Mrs Mulligan for attending on behalf of their respective Directors.

1. Minutes of Previous Meeting

The minutes of the Executive Team meeting held on 24 July 2019 were considered and approved.

2. Matters Arising/Action Log

Members considered the following items listed on the Acton Log.

2.1 Trust Healthcare Science Leads

Mrs Owens advised that Mr Dawson, at a previous meeting, had nominated a Healthcare Science Lead.

Dr Jack undertook to respond to Professor Young, DoH.

2.2 Pensions Annual Allowance Issue

Mrs Edwards undertook to circulate briefing paper to relevant staff for information.

It was noted the Mr Dawson, DoH had issued a template to Trusts to assess the impact on services as a result of the new tax allowance arrangements.

2.3 Mater Capital Bid

Dr Jack advised Bishop Treanor had written to the Trust confirming the £15m YP capital funding to support the development of theatres on the Mater site, in line with New Directions 2.

2.4 Mandatory Training

Mrs Diffin confirmed she had circulated the DCCS Mandatory Training Database to members for consideration.

2.5 Shared Services Recruitment

It was noted Mrs Kennedy had issued a template to capture evidence of specific problems with BSO recruitment over past 6 months.

2.6 Kingston NHS Foundation – Proposal for Theatre Nurses

Mrs Stoops confirmed a briefing paper on the Kingston Theatre Nurse proposal had been submitted to the DoH for consideration.

Members commented on the need to meet the timescales for the proposal (commencing September) and Miss Creaney undertook to follow up with the CNO.

2.7 TIG – 14 August 2019

Mr Dillon confirmed there would be a presentation on the Culture Report to the TIG meeting being hosted by the Trust on 14 August 2019.

2.8 Chief Executive Forum

Mrs Stoops confirmed she would be presenting a paper on Coding to ET on 14 August, 2019.

In relation to the status of the Helipad, Mrs Edwards advised she had a meeting scheduled with Miss Brookes and would provide an update at the next meeting.

2.9 Launch of Regional Leadership Development Programme "Collective"

Members noted that potential nominees to be submitted to Mrs Kennedy.

It was also agreed that those had participated in the previous programme should be invited to present to a future meeting.

2.10 Finance Update – Audit Workshops

Mrs Edwards advised she had recently met with Mr Smyth, Chair of Audit Committee, to provide an update on progress in relation to the Audit Improvement Plan.

Mrs Edwards reminded colleagues that outstanding Directorates should confirm an Audit Workshop date as soon as possible. Mr Smyth had confirmed he would attend the DSHWH Audit Workshop.

Members noted an Audit Review meeting is scheduled for morning of 18 September 2019.

2.11 TIG – Elective Access Allocation

Mrs Stoops advised that Mrs Thompson was liaising with Mrs Cotter regarding clarifying the IR35 position in relation to Trust staff engaged by the IS.

2.12 Nurse Bank Incentivisation

Miss Creaney provided an overview of a recent teleconference with Director of Nursing colleagues regarding the Nurse Bank Incentivisation scheme. She expressed concern that there had, as yet been no discussions with the trade unions regarding the implementation of the scheme.

Members expressed concern at the potential impact on services if the scheme is to be implemented in September.

It was agreed that Miss Creaney, Mrs Edwards and Mrs Kennedy should meet to discuss prior to further discussion at the next ET meeting.

3. Chief Executive Update

3.1 TIG – 31 July 2019

Mr Dillon provided an overview of discussion at the TIG meeting he had attended earlier. There had been an update on Transformation funding, Workforce Strategy and the Nurse Bank Incentivisation scheme. The agenda and papers had been circulated to members.

In response to a comment from Mr Dillon regarding the presentation on "Benefits Realisation, Evidence Change" Mrs Stoops undertook to liaise with colleagues regarding the delivering together indicators.

4. QI Presentation

4.1 Improving Patient Flow After Cardiac Surgery

Mr Dillon welcomed Mr Graham and Dr McNeilly to the meeting.

Mr Graham and Dr McNeilly gave a presentation on the QI project "Improving Patient Flow After Cardiac Surgery". Dr McNeilly explained the Enhanced Recovery After Cardiac Surgery (ERACS) and outlined the service improvements introduced, which had resulted in a reduced length of stay in HDU. Mr Graham advised the improvements resulted in better patient outcomes, to date only one patient had required readmission.

Mr Graham referred to the "average critical care nights per spell following cardiac surgery" section of the Getting It Right First Time Report (GIRFT) and highlighted the Trust improvement since 2013.

Mr Graham advised that some colleagues had been sceptical at the beginning of the project, however they are now champions supporting the improved patient experience. In concluding he paid tribute to all colleagues across services who had been integral in the success of the QI project.

In the discussion which followed members commended the project, which empowered nursing staff to introduce new ways of working.

Mr Dillon thanked Mr Graham and Dr McNeilly for their commitment and passion to improving patient outcomes and they then left the meeting.

5. Safety, Quality, Experience

5.1 Muckamore Abbey Hospital (MAH) Update

Miss Creaney (on behalf of Mrs Heaney) presented the MAH Sitrep report for the week ending 21 July 2019. In considering, the contents of the report members noted there were a total of 60 patients, with 1 admission and no discharges during the reporting period. Dr Jack confirmed that the weekly Sitrep report should also be shared with Ward Sisters/Charge Nurses.

Miss Creaney advised that following the meeting with Cranfield staff a number of actions are being followed up including considering having security staff on site.

Miss Creaney expressed concern that the regional admission protocol was not being followed as she had been contacted over the weekend as Director on Call regarding a NHSCT patient in police custody.

Following a comment from Dr Jack, Miss Creaney undertook to follow up with Mrs Heaney if the protocol had been formally approved. She also undertook to circulate the protocol to Director colleagues who may be contacted when on-call.

Members expressed disappointment in relation to the breakdown of two community placements. This served to highlight the challenges facing the resettlement programme.

Mrs Owens provided feedback following a recent Safety Quality visit to Erne; whilst there were patients with complex needs, they were receiving safe compassionate care. She had undertaken to follow up an issue raised regarding an outstanding psychology report for a patient.

Mr Dillon referred to a recent Safety Quality visit Mr McNaney had undertaken with Dr Jack and advised that Mr McNaney had heard directly from staff about the need to enhance staffing levels. It was noted that supply remains a real issue, but not all vacancies were back filled with agency staff.

Miss Creaney advised that whilst she understands nursing staff are dealing with challenging and complex issues, she pointed out, whilst there has been a reduction in patient numbers there has been no reduction in the nursing workforce. This has only been possible with the use of agency staff. She further advised that following the recent successful recruitment event a number of offers of appointment had been made, however these staff will not take up post until September.

Miss Creaney confirmed she had responded to recent correspondence from the RCN providing information requested in relation to workforce and rotas during the recent holiday period.

Members noted that the NMC had completed a review of staff currently suspended. Miss Creaney advised a meeting was scheduled for 1 August to review all MAH nurse suspensions and enhanced supervision.

It was noted the East London Foundation Trust report was due to be received at the end of July.

Miss Creaney advised the PSNI meeting scheduled for 2 August had been cancelled.

5.2 Infected Blood Inquiry (IBI)

Mr Boyd confirmed that the Trust had submitted 3 Rule 9 responses to the IBI on 25 July, 2019.

5.3 Live Governance

Dr Jack presented the Live Governance report for the week ending 24 July 2019.

Reference was made to the BHSCT/EA/19/49 and the delay in submitting the Early Alert. Ms Stoops explained the delay in investigation retrieving the records relating to this case, she acknowledged that there was learning for the Trust in respect of this incident.

Dr Jack undertook to reissue the DoH guidance in relation to the Early Alert Notification process.

5.4 HCAI Recovery Plan – Update

Miss Creaney presented the HCAI Recovery Plan for the period ending 29 July 2019 and was pleased to report there had been no further cases of Cdiff or MRSA in the past week. However, performance remains above last year's outturn and the need for rigorous focus on improvement continues.

Miss Creaney provided an overview of discussion following an earlier meeting with PHA colleagues regarding HSCI performance. Whilst the BHSCT is not an outlier compared to the region, it has 75% of HCAI compared to 50% in other Trusts. The targets for 2019/20 are anticipated to be similar to those of 2018/19, however given the Trust's performance at year end there needs to be focus on improvement. Miss Creaney had advised PHA that the Trust would be submitting a business case in respect of an IPC Speciality Team and she had highlighted to the PHA, whilst BHSCT is the largest Trust it receives same resource as other Trusts.

Members noted that surgery site surveillance i.e. caesarean section, general surgery will be included in targets next year, which will be challenging for the Trust.

Dr Jack proposed surgery site infections be included in ward performance dashboards.

Miss Creaney referred to the need for a consistent application of ANTT by clinicians and advised Dr Rocks had agreed to undertake a small QI project in Wad 7D in relation to the use of ANTTs.

In concluding the discussion, Mr Dillon emphasised the importance of a relentless focus on improvement in the HCAI performance.

5.5 Establishment of a HSC Regional Adverse Incident Reporting System

Dr Jack advised that each Trust is to run reports of adverse incidents on a periodic basis to be shared with the HSCB/PHA. The HSCB/PA will further interrogate the data from a regional perspective in order to identify themes and trends and to improve preparedness for regional participation in a nation learning system.

Members noted that each Trust will submit one weeks's worth of incidents initially in order to test the process and identify any issues. The chosen week is 13-19 May, to be submitted by 2 September 2019. Dr Jack emphasised the importance of these incidents being accurate and up-to-date prior to submission. She asked that Directorates quality assurance all relevant incidents to ensure any amendments are made by 23 August.

It was noted that Corporate Governance would issue guidance to Directorate Governance Managers.

6 Service Delivery

6.1 Unscheduled Care Update

Mrs Owens advised that the PHA was hosting a meeting on 14 August for each Trust to present Winter Resilience Plans for 2019/20 and advised Dr Armstrong would be liaising with colleagues in preparation for this meeting.

Members expressed sympathy to the wife and family of Dr John Gray, ED Consultant, Ulster Hospital, following his sudden death at the weekend. Dr Gray had formerly worked for the Trust.

Mrs Owens advised that BHSCT ED Consultant staff would be providing cover for the Ulster Hospital ED on Friday morning to allow colleagues to attend Dr Gray's funeral. Mr Dillon advised that Mr McGoran, SEHSCT had expressed his appreciation to Mrs Owens for putting these arrangements in place.

6.2 Mental Health Capacity (MHC) Act

Mrs Diffin advised she was seeking clarification from the DoH regarding staff required to undertake the MCA training and from the HSCB in relation to the IPT. She advised that she would need support from Planning Department to complete the IPT.

Members acknowledged the huge amount of work required within a short timescale.

Mrs Diffin referred to correspondence from the RQIA advising of their intention to seek assurance as to preparation and implementation of MCA in the lead up to the commencement date of 1 October 2019. Thereafter inspectors may enquire as to the extent of preparation for MCA in relation to any patient or client determined to have been deprived of their liberty.

Mrs Diffin advised a scooping exercise is being undertaken regarding training needs and she is planning to introduce a sub-committee structure to support MCA. She referenced the need for a Project Manager and additional admin support to deal with the additional workload.

Dr Jack advised the Medical Directors had a teleconference arranged to discuss concerns regarding the impact on service delivery in respect of the MHC.

6.3 Increased Capacity for Corporate Communications

Discussion deferred to future meeting

6.4 OP Waiting Times GP

Ms Stoops presented the quarterly waiting times for emailing to all GPs via the Integrated Care Department, HSCB.

Members approved the content of the report for issue.

Ms Stoops undertook to review the publishing of future reports on the Trust website.

7 Strategy and Partnerships

No items raised.

8 People and Culture

8.1 Media/PR Update

Mrs Dalzell provided an overview of recent media/PR coverage relating to the Trust.

Members noted that BBC True North airing a programme on PTSD, which would feature Dr John O'Hanlon.

Mrs Dalzell reported that she would be attending a preview of the Hospital NI programme.

9. Resources

9. 1 Finance Update

Mrs Edwards advised the draft financial plan 2019/20 had been submitted to the HSCB on 22 July and undertook to circulate copies.

Members noted a significant level of savings has been assumed in arriving at the £30m funding gap, which have not yet been identified. Over the next few months it will be important to identify all opportunities for savings and develop action plans. Mrs Edwards advised the Trust will need to provide assurance that there is a firm handle on spend, particularly discretionary spend, and continue to minimise waste and non-essential spend, to demonstrate commitment to good financial management and optimal efficiency in the use of resources. This will be crucial if the Trust gets to a point where there is nothing more that can be done before looking at measures which affect services.

Mrs Edwards advised that the MORE meeting on 13 August will focus on potential opportunities for savings prior to consideration by the Senior Leadership Group on 21 August.

9.2 Transformation Projects Update

Ms Stoops advised there was no further update in respect of Transformation schemes.

10. Any Other Business

10.1 Performance Improvement Trajectories

Ms Stoops provided an overview of the proposed Performance Improvement Trajectories for 2019/20.

Following discussion Ms Stoops undertook to further review the targets further and include on the agenda for the August Senior Leadership Group.

11. Date of Next Meeting

Members noted the next meeting was scheduled for 1.30pm on 7 August 2019 in the Boardroom Trust HQ.