Muckamore Abbey Hospital Inquiry

Organisational Module 7 – MAH Operational Management

WITNESS STATEMENT OF JACQUI AUSTIN

I, Jacqui Austin, retired Service Improvement and Governance Manager, now returned into a part time Administration post within the Litigation team in Muckamore Abbey Hospital 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 7 March 2024. The statement addresses a set of questions posed to me relating to MAH Operational Management.

2. This is my first witness statement to the MAH Inquiry.

3. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "JA1".

4. The 7 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 am a qualified Nurse and up until retirement, in December 2020, I was registered on Part 1 of the Nursing Midwifery Council.

6. I have held the following positions within the Belfast Health and Social Care Trust ("the Belfast Trust") or its predecessor:

a. 2003 to 2007, I held the position of Ergonomic Advisor in Risk Management within the Royal Hospitals

b. 2007 to 2008 I held the position of Governance and Quality Manager within the Head and Skeletal Directorate.

c. 2008 to 2010, I held the position of Governance and Quality Manager in Specialist Services Directorate.

d. 2010 to 2016, I held the position of Governance and Quality Manager for Older People's services.

e. 1st November 2016 to 1st December 2020, I held the position of Service Improvement, Governance Manager in Adult Social and Primary Care, which incorporated Intellectual Disability (ID), Mental Health and Older Peoples services. My office was in Fairview Crumlin Road Belfast.

f. On 26th January 2021 I returned to work as into a part time administration post within the Litigation team in MAH within the Belfast Trust.

<u>Questions for witnesses working in a management position at MAH</u>

Question 1

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

i. **The cohort of staff for which you had leadership and/or management responsibility.**
ii. **The day to day responsibilities of your role.**

My role in the management of MAH.

7. My first experience of working within Muckamore Abbey Hospital ("MAH") was in November 2016, when I became the Service Improvement, Governance and Modernisation Manager in Adult Social and Primary Care, which incorporated Intellectual Disability.

8. This was a directorate level position. My remit extended to the whole of the Adult Social and Primary Care Directorate (“ASPC”), which as the MAH Inquiry will know, included MAH. However, I do not consider this to have been a role in the management of MAH. I attended the Intellectual Disability Senior Management Team (SMT) meeting to discuss specific governance issues and I occasionally attended the Ward Sister meeting to discuss specific governance issues for example Belfast Risk Assessment and Audit Tool (BRAAT) or incident recording. I do not consider myself to have ever held a role in the management of MAH.

9. It may therefore be helpful if I explain where my position sat in the overall structure of the Directorate, as this will provide the context for my answers which follow.

10. As I have said, my position was a directorate level position. I reported directly to the Director of ASPC, Marie Heaney.

11. I had responsibility for overseeing governance arrangements throughout ASPC. I oversaw the Divisional level Governance and Quality Managers (as well as some other staff positions). I attach a structure of the Service Improvement and Governance team behind Tab 2.

12. This structure depicts the structure of Service Improvement & Governance within ASPC from December 2019 onwards. From this structure, it can be seen that from this time I was the line manager for and oversaw 3 Band 8a members of staff, who were Governance and Quality Managers within the three Divisions within the Directorate: Intellectual Disability, Adult Community and Older Peoples Services, and Mental Health.

13. In addition, as the structure shows, I was the line manager for a Band 6 Resource Nurse and a Band 6 Quality and Information Manager.

14. I explain the role of these positions further below.

15. I would not therefore ever have been considered to be involved in the management of MAH. However, I have answered the below questions as best I can and from the perspective of a person in a Directorate level position.

The cohort of staff for which I had leadership and/or management responsibility.

16. As I have outlined above, I had management responsibility for Governance and Quality Managers across ASPC. From December 2019 onwards, these included:
    a. Governance and Quality Manager for Older Peoples Services, based in the Mater Hospital. Band 8A
    b. Governance and Quality Manager for Mental Health Services, based in Mater Hospital. Band 8A
    c. Governance and Quality Manager for Intellectual Disability Services, based in MAH. Band 8A

17. Before December 2019, the one difference was that the position of Governance and Quality manager for Intellectual Disability Services had been vacant since the time I took up my post, in November 2016.

18. I also had management responsibility for
    a. Resource Nurse based in MAH. Band 6
    b. Quality and Information Manager, based in Mater Hospital. Band 6. The person also managed a team of 10 admin staff.
    c. Medical Workforce Manager, based in Mater Hospital. Band 7. This person also manages a team of 3 admin staff.

19. In addition, I had responsibility for the Admin Team within Mental Health and Intellectual Disability, I do not consider that it would be useful for the purposes of the below questions to go into that role in any further detail. However, I will of course provide any further information in that regard if the MAH Inquiry would find it helpful for me to do so.

20. The only post for which I was a professional line of supervision was the Resource Nurse at MAH.

21. As I have stated above, only two of these positions are related to MAH. They are the Resource Nurse and the Governance and Quality Manager for ID Services.

The Resource Nurse.

22. This was a post that had been appointed in the 1990s. The original Job Description can be seen behind Tab 3 of the exhibit bundle. The general description as per the original job description was that the Resource Nurse had "a wide range of duties in relation to the development, control and efficient management of Information Services and for the maintenance of professional standards", although this had been amended over time.

23. The job description was outdated, referring to systems that were no longer used within the Belfast Trust or MAH.

24. I therefore worked with the Resource Nurse to update and amend the job description to reflect the role more accurately. The amended job description was approved by the Head of Services for Intellectual Disability, and forwarded to Human Resources for Band matching. This process did not complete before my retirement, in December 2020, but I have provided a copy of the updated job description behind Tab 4 of the exhibit bundle .

25. The day to day responsibilities of the role were as follows:
    - To provide support and co-ordinate Regulation, Quality and Improvement Authority (RQIA) inspections within Intellectual Disability services, collate information for RQIA and produce reports on learning for dissemination
    - To assist in training, audit and development in the assessment and care planning process for nursing service
    - To provide support and carry out audits within the directorate.
    - Provide service improvement and governance advice to Ward Managers/Nursing Staff.

- To provide Mental Health, Learning Disability and Children and Adolescent Mental Health Services (CAMHS) multidisciplinary teams with relevant information to facilitate service improvement and learning
- To develop and maintain IT databases to ensure accurate, timely and effective information.
- To liaise with IT in relation to ongoing development of patient Information systems
- To co-ordinate and support staff in reviewing and writing operation policies and procedures in accordance with Trust procedures
- To participate in appropriate internal and external working groups / committees / projects relevant to service improvement and governance and liaise with multi-disciplinary personnel and outside Agencies/Trusts/Boards as required.
- Manage, review and update directorate risk registers in relation to Mental Health, Learning Disability and CAMHS
- Provide support in relation to audit within Learning Disability services
- Work collaboratively with the multidisciplinary team.
- Maximise the use of IM&T to support the multidisciplinary teams in the Directorate in the planning, delivery and evaluation of care.
- Provide support for Serious Adverse Incidents within the Service group
- Provide support for the Independent Chair multi-disciplinary review meetings including record security, liaising with the Risk department and Service Group managers.

26. While the Resource Nurse was not a specific role to MAH and had responsibilities in respect of Intellectual Disability, Mental Health and CAMHS, it was a position that was based at MAH. I also understand that the Resource Nurse's time was not spread equally between these three roles, with Intellectual Disability, and specifically, MAH, demanding more time than other areas.

27. While much of the above job description is self-explanatory, it may be helpful if I explain that in practice, the Resource Nurse prepared reports at various levels for

the purposes of information sharing. For example, she compiled reports that were considered at the various meetings which related to Intellectual Disability or MAH.

28. The Governance and Quality Manager for ID Services. No one was in post when I took up the role of Service Improvement and Governance Manager in 2016 but I considered it to be necessary and discussed this with the director of ASPC and the Head of Service for Intellectual Disability. When it was agreed, I identified a budget to create the post. The post holder was recruited in December 2019.

29. The Governance and Quality Managers were responsible through the senior Manager for Service Improvement and Governance for the delivery of risk management arrangements appropriate to the requirement of the Directorate.

30. I have provided a copy of the job description for the Governance and Quality Managers as behind Tab 5 of the exhibit bundle. As per that job description, the day-to-day responsibilities of the post were:

> "The post holder will be responsible for providing professional leadership through effective integrated governance and patient/client safety and will lead the Directorate in the development of quality improvement plans. He/she will be responsible for the maintenance and continual review of the Directorate risk register and assurance framework.
>
> The post holder will co-ordinate Directorate reports and responses to statutory and other external bodies such as the DHSSPS and the RQIA. He/she will encourage a multi-professional approach to all his/her areas of work, ensuring clinical and social care staff engagement in risk management and governance."

31. In principle, the concept of having two members of staff based at MAH meant that they could provide governance support at hospital level, escalate concerns and disseminate information as appropriate. The Covid Pandemic meant that the newly appointed Governance and Quality Manager had to work from home, to shield on

the basis of medical advice and was therefore unable to physically come into work from March 2020 until I retired in December 2020.

32. Neither the Resource Nurse or Governance and Quality Manager were involved in Operational Management of MAH.

The day-to-day responsibilities of my role.

33. I was responsible for leading and co-ordinating the service improvement and governance agenda within the Directorate. I was required to establish robust communication systems across the Directorate to disseminate and receive information about the service improvement and governance agenda to enable all staff, service users and carers to participate in service modernisation.

34. As I have explained above, I had line management responsibility for the Governance team, the Medical Workforce team and the Senior Management team administration staff in the Directorate.

35. I worked closely with the three Co-Directors to ensure compliance with the governance agenda and had lead responsibility for particular elements of clinical and social care governance.

36. I was also the lead for liaison with RQIA for the Directorate. I have attached the job description for the post I held behind Tab 6 of the exhibit bundle.

Question 2

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

- **i. How patients were referred for admission.**
- **ii. Who was involved in the referral process.**

iii. What factors impacted whether someone was able to stay at home or in the community or whether they were referred to MAH.

iv. Specifically, did lack of resources or delay in availability of support in the community impact on whether a patient was referred to MAH? If so, please explain.

v. Were other options to enable someone to remain at home or in the community always explored prior to the decision to admit them to MAH?

vi. How was it decided when a patient was ready for discharge from MAH?

vii. Were there patients at MAH for whom discharge was never considered? If so, why?

My role in relation to the admission and discharge of patients to MAH.

37. As I have outlined above, my role was in the service improvement and governance agenda within the Directorate. I did not therefore have a role in the admission and discharge of patients and do not consider I can comment on this question.

Question 3

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

38. As I have outlined in the course of answering question 1 above, I would not have been considered to be part of management at MAH, so I am unable to say how regularly management meetings took place. However, I would on occasions have attended the Ward Sisters' meeting to discuss specific governance issues; for example completion of BRAAT or incident reporting.

39. In the Learning Disability Division, I was invited to the Senior Managers Team Meeting, which took place once a month, my role within that meeting was to advise on governance issues.

Question 4

Did MAH managers receive regular reports on:

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

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

40. I am only able to answer this question from the perspective of a person in a Directorate level position. Any managers who attended the Intellectual Disability Services Governance Meeting received reports concerning the use of seclusion, the use of physical intervention, complaints and safeguarding. The only report listed above that a report was not produced on for the purposes of the Intellectual Disability Services Governance Meeting was the use of PRN medication.

41. I provided reports at governance meetings with the expectation that the attendees at the governance meetings would share the reports more widely within the division.

Question 5

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

42. I was not part of the process of co-production between staff and relatives at MAH in the course of the care of patients at MAH. However, I did have a role in the procedures and processes to ensure co-production existed in two ways.

43. First, I had a role in the complaints process for patients at MAH. My role was to ensure that the complaint was recorded and registered with the complaints department and answered in a timely manner. During this process I ensured that the person who had made the complaint, who was often a relative of the patient, was kept up to date and involved in the process as and when required.

44. Secondly, I would have had oversight of complaints and adverse incidents. On occasions I may have been asked to carry out a review using Significant Event Audit (SEA) methodology. On occasions the subject matter or the learning identified from such incidents was a breakdown in co-production. One such incident occurred following the breakdown of a community placement. I chaired a meeting with the family and all parties involved in the discharge. The learning from this investigation is documented on the SEA report which I have included behind Tab 7 of the exhibit bundle. In the section entitled “Why did it happen?”, one of the points identified was that “Communication between all the parties declined during the last few months prior to, leading up to and during” the patient’s placement. Various points which relate to co-production are referred to throughout the report, including that one of the recommendations was that “Family must be involved in all decision making processes”.

45. This is an example of my involvement in ensuring that when a failure in co-production exists that it is identified and acted upon.

Question 6

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

46. As with the above question, I was not part of the process of co-production between MAH staff and community teams. However, as stated above when complaints or adverse incidents occurred which identified a problem in this area, I may have been asked to investigate this. If complaints or incident data suggested a problem was

emerging as a trend in this area I would raise this with the head of service. The same SEA report that I have included behind Tab 7 of the exhibit bundle , also identified learning and recommendations in relation to MAH staff and community teams. For example, the report comments that “There needs to be connectivity when a patient is discharged to a supported living environment” and “The Trust accepted a collective approach to support the placement up to 3 years”.

Question 7

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

47. I did not, in my position, work with patients nor oversee that process. I do not therefore consider that I can comment on such matters.

Question 8

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

48. As the Service Improvement, Governance Manager for the Directorate, it was my role to ensure that staff were aware of all new policies. I represented the directorate at the Trust Policy Committee so I was aware of all new polices. I brought details of new policies to Intellectual Disability Services Governance Committee. The staff who attended that Committee were in turn expected to bring the policies from the Committee to the staff cohort that they were responsible for and ensure that their staff were aware of the new policies.

49. In addition, as the representative of the directorate at the Trust Policy committee, I presented new policies from within the directorate to the committee for approval.

50. Each level of manager was responsible for ensuring that their staff cohort were aware of the new policies thus creating a cascading effect throughout the levels.

In addition, employees are expected to keep themselves up to date with Trust policies.

51. Incident data, complaints and audit provided information on adherence to policy. If there were issues of non-adherence to policy this would be brought to the attention of the Head of Service and / or discussed at governance meetings.

52. Some policies required formal monitoring of adherence such as the hand hygiene policy and the seclusion policy. Where this is the case, it is noted on the policy itself. The resource nurse carried out audits for these, and these were shared at governance meetings.

Question 9

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

53. In my position, I was not part of this process. I do not therefore consider that I can comment on such matters.

Question 10

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

54. As Service Improvement, Governance manager within Adult Social and Primary Care, when I took up post in 2016, I only managed one member of staff who was based at MAH, her position was not restricted to the operational limits of MAH. After December 2019, I also managed the newly appointed Governance and Quality Manager. I can therefore only speak to the performance management arrangements that I conducted in relation to those two staff members and the performance management arrangements that I was subject to.

55. I conducted monthly supervision meetings in order to monitor and manage performance of the Resource Nurse and the Governance and Quality Manager. These meetings were on a one to one basis. The agendas were often quite similar in substance. I have attached an example agenda for such a meeting behind Tab 8 of the exhibit bundle. A brief hand written note of the meetings were held within the individual's file. These files were given to the person who replaced me, after retirement, and I do not have access to them now.

56. My own supervision worked in the same way. I had one to one supervision meetings with the Director of Adult Social and Primary Care.

Question 11

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

57. As I have said above, as Service Improvement, Governance manager within Adult Social and Primary Care, I managed two members of staff who were based at MAH, one of whom was shielding from home for the majority of the time period that we were both in post. We discussed professional development as part of our monthly supervision meetings. We used the Staff Development Review process as outlined in Trust policy. I have attached an example Staff Development Review (SDR") behind Tab 9 of the exhibit bundle. During our monthly meetings, we discussed training and development opportunities. We also updated the job description for the role and sent it to HR for job evaluation. This process had not concluded before I retired but it was imperative that we worked to the newly created job description for Quality and Information Manager.

58. Specific development opportunities were: Involvement in Safety Quality Belfast, more inclusion in incident investigations and identifying training to support that. Involvement in shared learning forum and actively sharing learning identified through investigation or complaints.

Question 12

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

59. I did not have a role in workforce monitoring, planning and implementation. The only time I would have been aware that there were problems with workforce was if an Adverse Incident form was submitted because of staff shortages or if such matters were discussed at the ID Governance Committee meetings.

Question 13

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

60. As I have outlined, I was not considered part of MAH management. However, I am aware from having managerial responsibility for the Resource Nurse, that she was tasked with producing reports on incident reporting, complaints, safeguarding amongst other things for meetings which existed at various levels of the managerial structures. The Resource Nurse also carried out audits on issues such as care planning, seclusion and hand hygiene adherence.

61. The purpose of these reports was to allow the recipients to perform data analysis and trend identification, which was more particularly a part of the role of the Governance and Quality Manager.

62. These reports, data analysis and trend identification also occurred at Divisional level through the ID Governance Committee. Data analysis and trend identification could occur with varying degrees of formality. At each meeting, there was a general analysis of the reports produced for that meeting. For example, at the first meeting I attended on 18 January 2017, I identified and advised those present that ID Services still had the highest incidents in abusive, violent, disruptive or self-

harming behaviour. I also advised that staff absence had increased from previous months. I have attached the minutes for this meeting behind Tab 10 of the exhibit bundle.

63. On other occasions, there was a more detailed audit and consideration. An example can be found in the Management of Complaints 2016/2017 audit which was discussed in the May 2017 meeting at which I advised of the takeaway points from the internal audit contained within the meeting's papers. I have attached the minutes for this meeting behind Tab 11 of the exhibit bundle.

Question 14

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

64. I did not work at hospital level nor did I oversee hospital level staff who were involved in the use of seclusion. However, I received seclusion reports as a regular paper at the ID Services Governance Meeting, which I attended. I reviewed these reports in the ways I have described above and escalated any concerns to the Head of Service

Question 15

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

2014

65. In February 2015 while I was Governance and Quality Manager for Older People's Services, the then Service Improvement, and Governance Manger, Mairead Mitchell (to whom I reported) asked me to review two instances of reported patient abuse in MAH. Whilst Intellectual Disability Services was not part of my remit at

that time, I was happy to review the incidents as requested. It wasn't uncommon for Governance and Quality managers to review incidents in other areas.

66. These incidents both met the criteria of Serious Adverse Incidents and were reported as such to the Health and Social Care Board. One incident became SAI/114/68, the other became SAI/14/102. The methodology used for the review was SEA. I was the lead facilitator for the review. I was assisted by the Operations Manager for MAH, the Senior Nurse Manager for MAH, a Ward Sister at MAH and a Consultant Psychiatrist at MAH. The reviews noted that the incidents had happened in the preceding 12 months. It was also noted that the members of staff, accused of the abuse had been suspended and the incidents reported to the PSNI.

67. The SEA review also noted that other staff on the wards had reported the incidents, to the nurse in charge who in turn immediately reported it to the Senior Manager on site.

68. Perhaps the best summary of the action taken in relation to SAI/14/102 can be found in the correspondence that was sent to the Health and Social Care Board in relation to it which read:

> "The Directorate confirmed that the incident was originally investigated through the safeguarding procedure. The outcome was sent to Public Prosecution but in consultation with the PSNI there was no indication that this would proceed to criminal prosecution. The case went to Trust Disciplinary and the decision of the panel was for the staff members not to return to the ward, there was to be supervised contact with patients and was to be subject to review in six months".

2017

69. On 21st August 2017, I also became aware of abuse of patients at Muckamore Abbey Hospital. I received a phone call from the then Divisional Nurse who told me that she had viewed CCTV footage in the presence of the Business and Service Improvement manager and had witnessed patient abuse by a member of staff. I asked the Divisional Nurse if she had escalated this information and recorded it.

She informed me that she had escalated the information to the acting Director of Adult Social and Primary Care and the Director of Nursing.

70. The acting Director of ASPC held an emergency meeting, which I attended, although I cannot remember the exact date and time. This meeting outlined actions that had been taken and what actions needed to be taken. I cannot remember the specific details of the meeting but the issues discussed included; informing families, staff suspension, creating an Early Alert notification to the Department of Health and discussion on how assurance could be provided to ensure ongoing safety of patients in MAH.

Question 16

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?

71. In the letter which asked me to provide a statement to the MAH Inquiry I was asked to answer the 16 questions above, which were appended to the letter. In addition, I was asked in the body of the letter, to provide information in response to the following question:

> **"What regular Risk and Governance meetings took place relating to MAH? In answering this question, please provide an explanation of:**
>
> i. **How often meetings occurred.**
> ii. **Who attended meetings?**
> iii. **Who decided the agenda for meetings?**
> iv. **What regular reports were provided for meetings?**
> v. **How were reports prepared, and by whom?**
> vi. **Who were reports sent to?**
> vii. **How were concerns escalated?"**

72. Two regular Risk and Governance meetings took place, which related to MAH.

a. At divisional level, the Intellectual Disability Services Governance Meeting took place quarterly.
b. From January 2019, a weekly Muckamore Live Governance Meetings started, these were in addition to the quarterly meeting.

73. I attended both meetings until the appointment of the Governance and Quality Manager. At that point, the Governance and Quality manager attended the weekly Live Governance meeting. I will answer the above questions in relation to each meeting in turn.

Intellectual Disability Services Governance Committee

74. The Intellectual Disability Services Governance Committee is the current name for a Committee which has existed since, at the latest, 2009. The purpose of the Committee, as per the sample Terms of Reference which I have exhibited behind Tab 12 of the exhibit bundle, is:

> "To provide assurance to the Adult Social and Primary Care Directorate Governance Committee that there are effective structures, systems and policies in place for the management of all aspects of the Governance Agenda in Intellectual Disability Services".

75. It was not always called the "Intellectual Disability" Services Meeting. I understand that there were various iterations of the title for the meeting during its existence. I can recall that before it was called the "Intellectual Disability Services Governance Committee" it was called the "Learning Disability Services Governance Committee".

i. How often meetings occurred.

76. The ID Services Governance Committee met quarterly when I was in post.

ii. Who attended meetings?

77. The meeting was chaired by the Head of Intellectual Disability Services. The Committee includes:

Head of ID Services
Senior Manager, Service Improvement and Governance
Divisional Chair, ID Services
Service Manager, MAH
Divisional Nurse, ID Services
Divisional Social Worker, IS Services
Service Manager, Residential, Supported Living and Day Care Services
Head of Psychology Services
Health and Safety Manager
Carers Consultant
Quality and Information Manager

78. However, any Senior Professional or Senior Manager within the Directorate or Trust can, where appropriate, could be invited to attend.

iii. Who decided the agenda for meetings?

79. By and large the agenda for the quarterly Intellectual Disability Services Governance Committee was standardised; I have attached a sample agenda behind Tab 12 of the exhibit bundle.

80. The chair of the meeting agreed the agenda.

iv. What regular reports were provided for meetings?

81. The sample agenda, attached, identifies the suite of reports that were presented. There were some differences from quarter to quarter but the standard reports were; Incidents reports, SAI reports, Complaints and Compliments reports, Risk register, Health and Safety report, Physical Intervention and Seclusion report, Adherence to the Mental Health Order (MHO) documentation report, Statutory Functions report. This list is not exhaustive.

82. Occasionally reports were added, if something new needed to be shared or omitted, if for example the presenter was not attending.

v. How were reports prepared, and by whom?

83. The Corporate Risk and Governance department sent Incident reports, SAI and Complaints/ Compliments reports to Adult Social and Primary Care directorate and the governance team within the directorate shared these at Intellectual Disability Services Governance Committee, for discussion.

84. The Resource Nurse in MAH prepared the Physical Intervention and Seclusion report.

85. The Divisional Social Worker prepared and presented the Statutory Functions report.

86. The Health and Safety Manager presented the Health and Safety report.

87. The Risk Register was updated and maintained by the Adult Social and Primary Care governance team and a "live" version of the Risk Register was provided for discussion.

88. RQIA reports were sent to the Trust Chief Executive from RQIA and when relevant these were shared and discussed at the Intellectual Disability Services Governance Committee.

89. The Quality and Administration manager in Adult Social and Primary Care prepared and presented the report of MHO documentation.

vi. Who were reports sent to?

90. All reports were sent out to those on the quarterly Intellectual Disability Services Governance Committee distribution list approximately 7 days prior to the meeting.

If there were attendees, who wished to present an additional report this was sent to the Chair of the meeting for approval before being including on the agenda.

vii. How were concerns escalated?

91. The Intellectual Disability Services Governance Committee reported to the Adult Social and Primary Care Directorate Governance meeting chaired by The Director of Adult Social and Primary Care.

92. The Chair could raise immediate concerns to the director and / or include them on the Adult Social and Primary Care Risk register.

93. The Chair and other members of the Intellectual Disability Services Governance Committee represented the Directorate on various Trust Steering Groups and Committees in the Trust Assurance Framework; this provided an escalation path for concerns raised at either, the Intellectual Disability Services Governance Committee or the weekly Muckamore Live Governance Meetings

Muckamore weekly Live Governance Meeting

i. How often meetings occurred.

94. I refer to the Terms of Reference, which I have exhibited behind Tab 13 of the exhibit bundle. This meeting was scheduled to occur weekly. On some occasions, the meeting was cancelled because of unavailability of ward staff and /or a chair.

ii. Who attended the meetings?

95. As per attached Terms of Reference the attendance was:

- The Chair of Division (Chair)
- The Clinical Director (co- chair)

- Governance and Quality Manager for ID
- Nursing Senior managers
- Charge Nurses/Ward Sisters Band 7

96. In addition, any Senior Professional or Senior Manager within the directorate or Trust will, where appropriate, be invited to attend.

iii. Who decided the agenda for meetings?

97. The weekly Muckamore Live Governance Meeting agenda was set by the template, attached in Tab 13, which was sent out to all wards for completion prior to the meeting.

iv. What regular reports were provided for meetings?

98. Reports were generally not shared at the weekly Muckamore Live Governance Meeting, its purpose was to focus on live governance information provided by ward staff.

v. How were reports prepared, and by whom?

99. There were no reports prepared for the meeting but ward staff completed a template prior to attending the meeting for discussion during the meeting.

vi. Who were reports sent to?

100. The template prepared by ward staff was sent to the Chair of the meeting prior to the meeting.

vii. How were concerns escalated?

101. Ward staff raised concerns at the meeting directly to the Chair, after discussion the Chair then either raised immediate concerns to the director and / or include them on the Adult Social and Primary Care Risk register.

Declaration of Truth

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

Signed:

Dated: 08/05/2024

Exhibit Bundle "JA1"

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Muckamore Abbey Hospital Inquiry

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

07 March 2024

By Email Only
Ms Jacqui Austin

Dear Ms Austin

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 now 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 understands that you were a Service Improvement, Governance and Modernisation Manager in the Belfast Health and Social Care Trust (BHSCT) from in and around 2016 to 2020.

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

M7: MAH Operational Management

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, spans across the Terms of Reference.

Please find enclosed a set of questions that the Panel wish to be addressed in your statement ("Questions for witnesses working in a management position at MAH"). 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.

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.

In addition, given your roles in Governance, the Panel would be assisted if your statement would also address the following question:

1. What regular Risk and Governance meetings took place relating to MAH? In answering this question, please provide an explanation of:

    i. How often meetings occurred.
    ii. Who attended meetings?
    iii. Who decided the agenda for meetings?
    iv. What regular reports were provided for meetings?
    v. How were reports prepared, and by whom?
    vi. Who were reports sent to?
    vii. How were concerns escalated?

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/9dj7nf4r1ew54m5ymqa2vvwkfamve2gc

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 witnesses working in a management position at MAH.

M7: MAH Operational Management
Questions to be Addressed in Witness Statement

Questions for witnesses working in a management position at MAH

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

   i. the cohort of staff for which you had leadership and/or management responsibility;
   ii. the day to day responsibilities of your role.

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

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

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

4. Did MAH managers receive regular reports on:

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

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

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

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

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

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

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

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

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

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

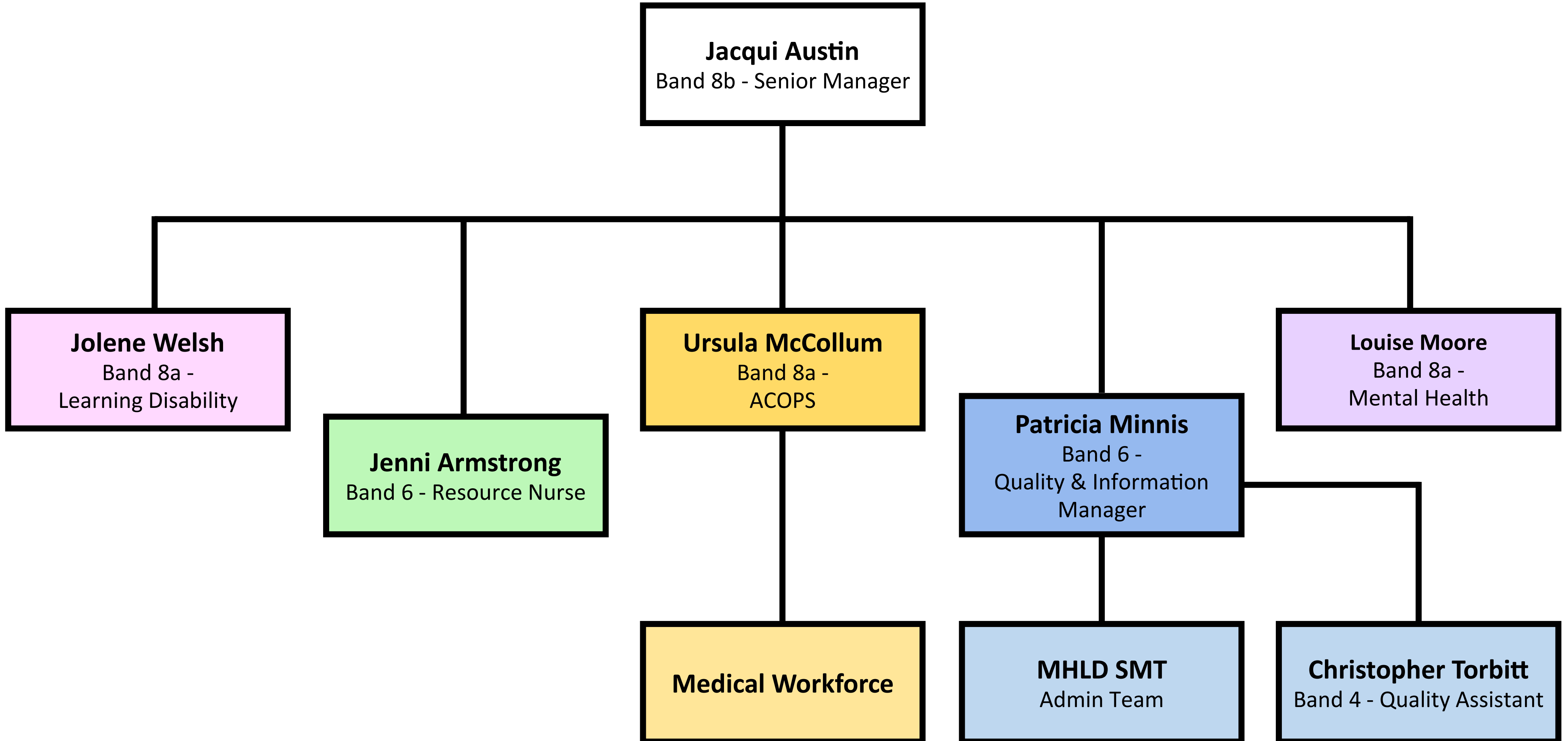
13. Did MAH managers carry out regular data analysis and trend identification? If so, please explain how this was done.

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

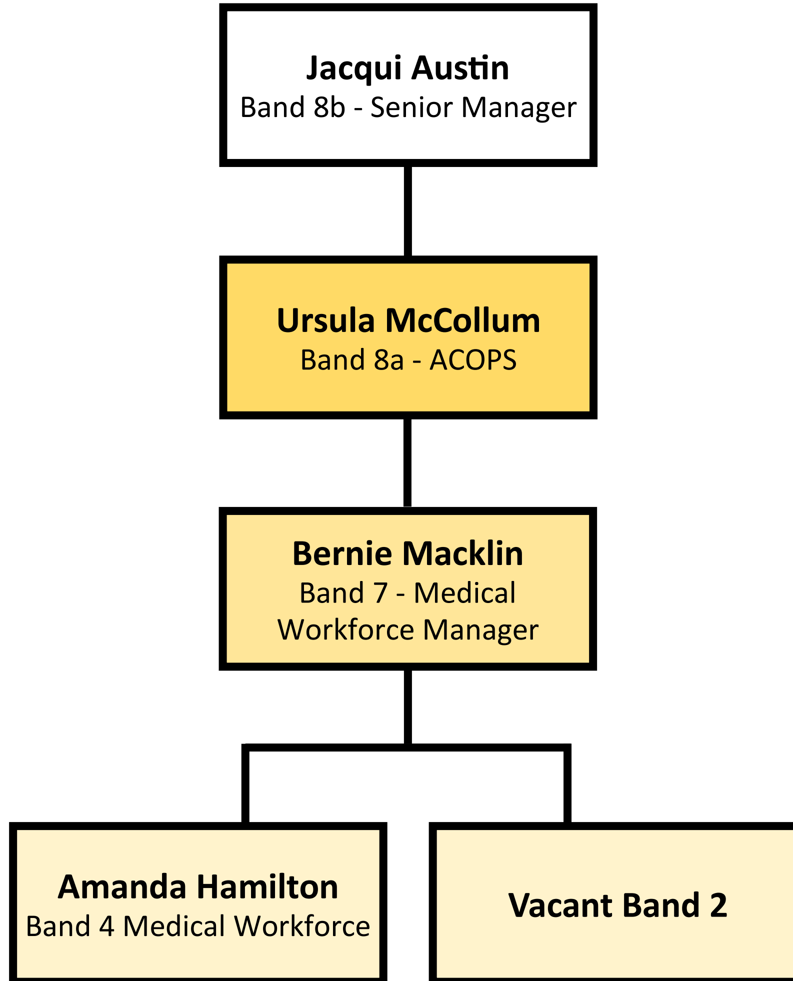
15. Please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at management level to address such concerns.

16. 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?

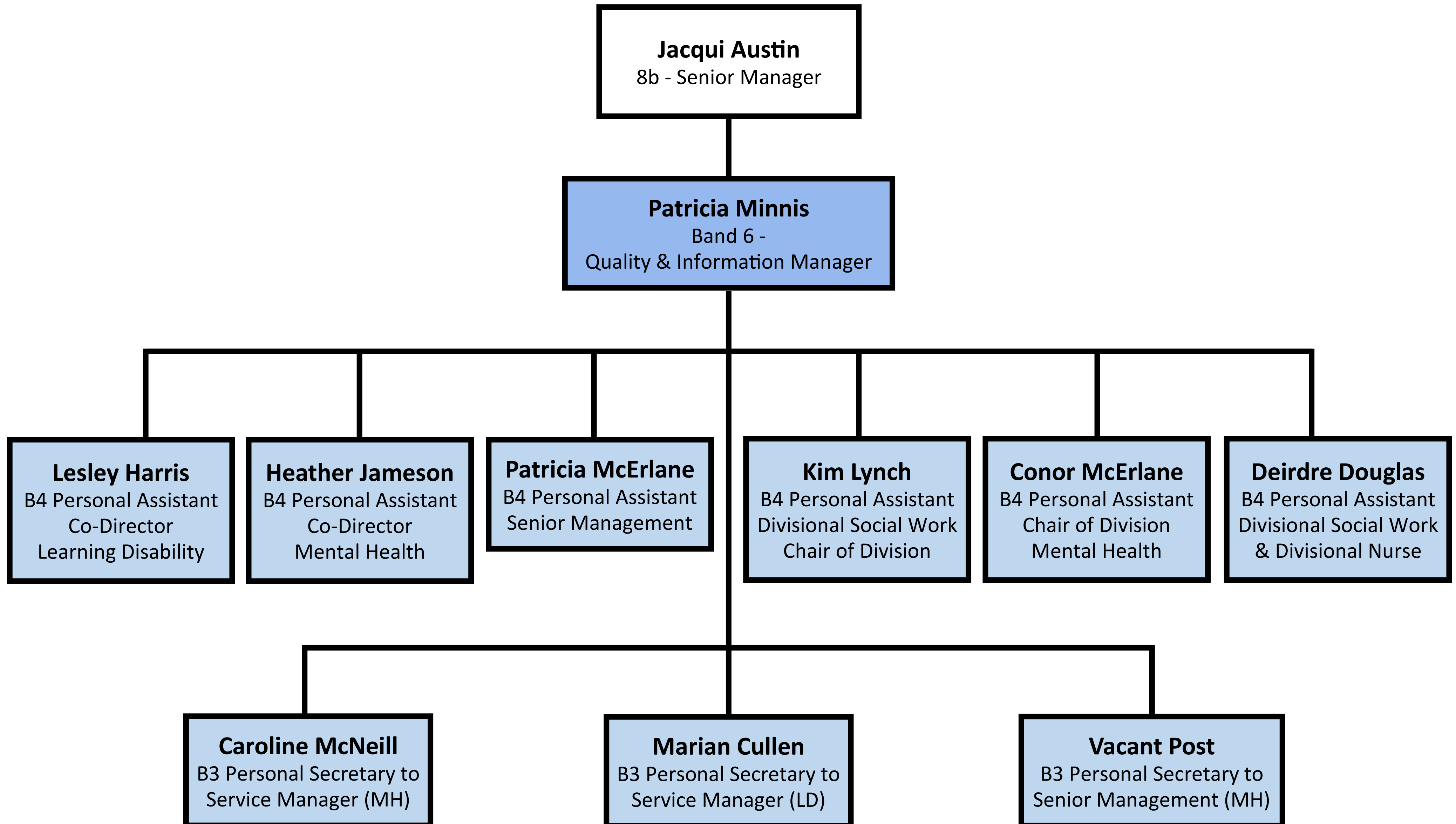
Service Improvement & Governance



Medical Workforce



MHLD SMT Admin Team



NORTH AND WEST BELFAST HEALTH AND SOCIAL SERVICES TRUST

MUCKAMORE ABBEY HOSPITAL

JOB DESCRIPTION

TITLE:	Resource Nurse Grade F
RESPONSIBLE TO:	Director of Hospital Services L.O.S.
REPORTS TO:	~~Nursing Services Manager~~ Asst Dir
LOCATION:	Muckamore Abbey Hospital

GENERAL DESCRIPTION

The Resource Nurse is responsible to the Asst ~~Nursing Services Manager~~ for a wide range of duties in relation to the development, ~~control and efficient management of Information Services~~ and for the maintenance of professional standards.

MAIN RESPONSIBILITIES

1. The Resource Nurse will be responsible for the management and development of EQUATE.
2. Participate in audits, data collection and carry out data analysis, in relation to EQUATE.
3. Preparation of reports (in relation to EQUATE), including dissemination to personnel.
4. Provide system management of the QUASAR system, within Muckamore Abbey Hospital, including liaison with Health International.
5. Contribute to the development of an Information and I T Training programme within Muckamore Abbey Hospital. Assist in the identification of training needs, co-ordinate and deliver training as appropriate, and assure the quality of its delivery.
6. Enhance and improve the presentation of information within Muckamore Abbey Hospital through the use of graphics, statistical and desk-top publishing applications.
7. Assist in the implementation of future Mental Handicap Information Systems initiatives in Muckamore Abbey Hospital.

8 Ensure that all provisions of the Data Protection Act are observed and maintained.

9 Responsible for ensuring that any information extracted is furnished only to authorised/appropriate personnel.

10 Preparation and presentation of standard and ad hoc reports and statistics as required by Nursing Services Manager, Senior Nurse Managers, Ward Reviews, and other disciplines.

11 Participate in research and project work, disseminate research findings and encourage staff to participate in nursing research

12 Participate in the setting, monitoring and auditing of Standards of Care.

13 Provide specialist nursing advice to Ward Managers/Nursing Staff.

14 Attend conferences and serve on relevant committees

15 Liaise with medical, paramedical and other staff disciplines as required.

This Job Description is not definitive and may be subject to review as the duties and responsibilities determine.

Please note that the Trust operates a "no-smoking" policy and all employees must comply with this.

The Trust is committed to providing the highest possible quality of service to residents, clients and community. Members of staff in Trust are expected at all times to provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

To promote equality of opportunity and good relations as outlined in the Trust's Equality Scheme.

To be aware of the Human Rights legislation in relation to the requirements of this post.

03 August 2000

I accept this Job Description as being acceptable to my position as a Resource Nurse Grade F.

Signed Joni McKay Date 28/7/04

Belfast Health and Social Care Trust

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JOB DESCRIPTION

POST: Quality and Information Manager

LOCATION: Mental Health & Learning Disability Services

Band: 6

REPORTS TO: Senior Manager for Service Improvement and Governance

RESPONSIBLE TO: Senior Manager for Service Improvement and Governance

JOB SUMMARY:

The post-holder will work to improve patient care through Service Improvement and Governance enabling and supporting all professionals in the delivery of high quality, evidence based person-centred care.

The post-holder will form part of a team that will promote service improvement and governance, through promotion, development and evaluation of professional standards.

The post holder will be expected to develop their current skills and acquire new skills in order to satisfy the developing governance needs for the Belfast Trust. The post holder will be dedicated to assuring that the services provided are responsive and of the highest quality.

PRIMARY RESPONSIBILITIES

- To provide support and co-ordinate RQIA inspections within Learning disability services, collate information for RQIA and produce reports on learning for dissemination
- To assist in training, audit and development in the assessment and care planning process for nursing service
- To provide support and carry out audits within the directorate.

- Provide service improvement and governance advice to Ward Managers/Nursing Staff.
- To provide mental health, learning disability and CAMHS multidisciplinary teams with relevant information to facilitate service improvement and learning
- To develop and maintain IT databases to ensure accurate, timely and effective information.
- To liaise with IT in relation to ongoing development of patient Information systems
- To provide co-ordinate and support staff in reviewing and writing operation policies and procedures in accordance with trust procedures
- To participate in appropriate internal and external working groups / committees / projects relevant to service improvement and governance and liaise with multi-disciplinary personnel and outside Agencies/Trusts/Boards as required.
- Manage, review and update directorate risk registers in relation to mental health, learning disability and CAMHS
- Provide support in relation to audit within learning disability services
- Work collaboratively with the multidisciplinary team.
- Maximise the use of IM&T to support the multidisciplinary teams in the Directorate in the planning, delivery and evaluation of care.
- Provide support for Serious Adverse Incidents within the Service group
- Provide support for the Independent Chair multi-disciplinary review meetings including record security, liaising with the Risk department and Service Group managers.

GOVERNANCE & PERFORMANCE:

- Contribute to ongoing developments in relation to governance, patient safety and service improvement within the service group
- Support the implementation of quality improvement initiatives
- Develop standards and guidelines to support mental health and learning disability governance structures in collaboration with multidisciplinary team.
- Ensuring that examples of excellence and innovation in governance and patient safety are promoted and shared widely throughout the Directorate and contribute to governance and patient safety workshops and conferences.
- Support multidisciplinary teams to deliver high quality person centred care.
- Support the development and implementation of the learning disability modernisation programme.
- Participate in projects in relation to service improvement and governance
- To provide written and practical support to staff on the implementation of new procedures and practices

General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's Smoke Free Policy.
- Carry out their duties and responsibilities in compliance with the Health and Safety Policies and Statutory Regulations.
- Adhere to Equality and Good Relations duties throughout the course of their employment.
- Ensure the ongoing confidence of the public in-service provision.
- Maintain high standards of personal accountability.
- Comply with the HPSS Code of Conduct
- Manage time well and help others to do so too.
- Demonstrate effective communication skills
- Demonstrate honesty and integrity
- Act as a role model demonstrating and exemplifying positive behaviours and attitudes and contributing to the future cadre of professional clinical leaders.

Records Management

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including e-mails. All such records are public records and are accessible to the public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004 and Data Protection Act 1998. Employees are required to be conversant with the Belfast Health and Social Care Trust policy and procedure on records management and to seek advice if in doubt.

Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognizes the key principle that "Cleanliness matters is everyone's responsibility, not just the cleaners" Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff.

This includes:-

- Cleaning hands either with soap and water or a hand sanitiser at the appropriate times (WHO '5 moments');
- Using the correct '7 step' hand hygiene technique;
- Being 'bare below the elbows' when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);
- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Values:

The Belfast Trust aims to recruit staff not only with the right skills but also with the right values to ensure the delivery of excellent patient care and experience. Staff will be expected to be committed to provide safe, effective, compassionate and person centred care by:-

- Treating Everyone with Dignity and Respect
- Displaying Openness and Trust
- Being Accountable
- Being Leading Edge
- Maximising Learning and Development

By embedding the above values, we will make a significant contribution to the delivery of the Trust's Vision.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community where relevant, in developing, planning and delivering our

services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

Clause: ***This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.***

Belfast Health and Social Care Trust

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JOB SPECIFICATION

POST: Quality and Information Manager

LOCATION: Learning Disability Services

ESSENTIAL CRITERIA:

1. A relevant degree or recognised professional qualification or equivalent/Higher qualification

OR
HNC/HND or equivalent/higher qualification business and administration management.

OR
4 years' experience in a role involving Information Management including at least 1 year at Band 5

2. Experience in the use of Microsoft office products including word, excel and PowerPoint.

3. The ability to establish and maintain effective working relationships with professional and managerial staff and various representative bodies.

5. A working knowledge of the HSCB /RQIA procedures for serious adverse incidents

7. Hold a full current driving license valid for the use in the UK and have access to car on appointment

DESIRABLE CRITERIA

1. Experience in working in Learning Disability or Mental health.

2. Recruitment and Selection experience.

3. Experience in staff management

Where educational/professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates, and one photocopy of same, issued by the appropriate authority. Only those

certificates relevant to the shortlisting criteria should be produced. If educational certificates are not available an original letter and photocopy of same detailing examination results from your school or college will be accepted as an alternative.

If successful, you will be required to produce documentary evidence that you are legally entitled to live and work in the United Kingdom. This documentation can be a P45, payslip, National Insurance Card or a birth certificate confirming birth in the United Kingdom or the Republic of Ireland. Failure to produce evidence will result in a non-appointment.

VALUE BASED RECRUITMENT

* Values Based Recruitment is a process adopted by the Belfast Trust to attract and select employees on the basis that their individual values and behaviours align with those of the Trust and incorporating the Healthcare Leadership Model.
It focuses on the ‘how’ and ‘why’ people do what they do.
Candidates who are short-listed for interview will need to demonstrate at interview that they have the required knowledge, skills, competencies and values to be effective in this new role.
In answering the value-based questions, you have the opportunity to share examples of when you have demonstrated values relevant to the Belfast Trust.

<u>Belfast HSC Trust Values</u>

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role.

RESPECT & DIGNITY

- Being respectful to others
- Showing compassion to those who need our care
- Acting fairly and even-handed
- Acknowledging the good work of others
- Supporting others to achieve positive results

OPENNESS & TRUST

- Communicating openly and consistently
- Listening to the opinions of others and acting sensitively
- Being trustworthy & genuine
- Ensuring that appropriate information is shared honestly

ACCOUNTABILITY

- Taking responsibility for your own decisions and actions
- Openly admitting your mistakes and learning from them
- Using all available resources appropriately
- Challenging failures and poor practice courageously

LEADING EDGE

- Actively seeking out innovative practice
- Participate in new approaches & service development opportunities
- Share best practice with others
- Promote the Trust as a centre of excellence

MAXIMISING LEARNING & DEVELOPMENT

- Act as a role model for the development of others
- Continuing to challenge my own practice
- Fulfil my own statutory mandatory training requirements
- Actively support the development of others

Belfast Health and Social Care Trust

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JOB DESCRIPTION

POST:	**Governance and Quality Manager, Adult Social and Primary Care**
LOCATION:	**To be agreed**
BAND:	**8A**
REPORTS TO:	**Senior Manager for Service Improvement and Governance**
RESPONSIBLE TO:	**Director, Adult Social and Primary Care**

Job Summary / Main Purpose

The Governance & Quality Manager, will be responsible through the Senior Manager for Service Improvement and Governance for the delivery of risk management arrangements appropriate to the requirement of the Directorate.

The post holder will be responsible for providing professional leadership through effective integrated governance and patient/client safety and will lead the Directorate in the development of quality improvement plans. He/she will be responsible for the maintenance and continual review of the Directorate risk register and assurance framework.

The post holder will co-ordinate Directorate reports and responses to statutory and other external bodies such as the DHSSPS and the RQIA. He/she will encourage a multi-professional approach to all his/her areas of work, ensuring clinical and social care staff engagement in risk management and governance.

Main Duties / Responsibilities

Setting Direction:

- To support the Senior Manager for Service Improvement and Governance in the development and promotion of an integrated governance and assurance framework.

- To influence the development of a trust wide open and learning culture.

- To ensure the comprehensive and consistent reporting of adverse incidents across the Directorate.

- To develop a quality improvement plan for the Directorate linked to the corporate plan.

Service Delivery:

- To advise the Senior Manager for Service Improvement and Governance and Collective Leadership Team in ensuring the Directorate's compliance in reporting and managing adverse incidents, with requirements of the relevant external bodies

- To co-ordinate, in conjunction with the Senior Manager for Service Improvement and Governance, Collective Leadership Team and other key stakeholders, the appropriate investigation of adverse incidents and advise accordingly including facilitation of (and where required leading) investigations where required.

- To maintain a system for the receipt, dissemination and action from relevant external bodies relating to medical devices e.g. NIAIC.

- To develop, in conjunction with the Senior Manager for Service Improvement and Governance, Collective Leadership Team and other key stakeholders, risk management systems and processes.

- To develop, maintain and continually review the Adult Social and Primary Care risk register and assurance framework.

- To collate and analyse data held on Directorate and controls assurance risk registers and other risk related databases.

- To analyse all the Directorate's complaints, adverse incidents and claims to determine trends, identify remedial action where appropriate and prepare reports to help inform improvements in practice and lessons learned, ensuring informed decision making.

- To advise and support the Senior Manager for Service Improvement and Governance in ensuring good health and safety practice for all the Directorate activities.

- To develop, in conjunction with key stakeholders, a Directorate Hospital Acquired Infection Reduction Plan.

- To identify key areas of risk in respect of the Directorate's undertakings and liaise with stakeholders in order to address issues.

Development and Innovation:

- To be proactive in identifying new ideas and initiatives to ensure patient safety and the quality agenda is maximised.
- To contribute to the development of training programmes on adverse incident reporting, risk identification and risk management.

Quality:

- To advise and support the Collective Leadership Team to ensure full compliance with the NI Controls Assurance Standards.
- To advise and support the Collective Leadership Team in ensuring relevant Statutory, Departmental and Trust policies are met.
- To develop, in conjunction with key stakeholders clinical/performance indicators and other tools within the Directorate that will assist in the identification and monitoring of risk.
- To support Directorate compliance with the Trust Quality Improvement Plan.
- To promote and develop user engagement in Directorate's actions on risk management and quality.

Collaborative working:

- To work collaboratively with risk and governance staff across the Directorate, estates and facilities and with Trust's office or risk and governance to build robust governance arrangements.
- To work collaboratively with colleagues in the Medical Director and Director of Nursing Offices and other key stakeholders in preparing appropriate responses to reports and recommendations from regional statutory and other bodies such as the DHSSPS, the NPSA and the Regulation and Quality Improvement Authority.
- To contribute to building effective partnerships and maximise multi-professional learning opportunities in an environment that supports the development of practice and service improvement.
- To ensure that examples of excellence and innovation in governance and patient and client safety are promoted within the Trust and externally through networking.
- To ensure that the needs of patients, clients and their carers are at the core of the way the Trust delivers its primary and secondary care services.

Communication and Information Management:

- To support the Senior Manager for Service Improvement and Governance and Collective Leadership Team in preparing informative and meaningful reports on a regular basis for Directorate and for the Trust's Assurance Committee.

- To support in the ongoing design and development of electronic systems to manage information in relation to risk registers and other risk related databases.

- To ensure information systems used for the co-ordination of risk and governance activity and information is maintained and quality assured for the Directorate.

People Management and Development:

- To provide leadership to staff within Adult Social and Primary Care Directorate on the matters of risk and governance to encourage team working and continuous quality improvement.

- To manage the support staff relevant to the post.

- To promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.

- To delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision-making whilst retaining responsibility and accountability for results.

- To participate in the Trust's Performance Review Scheme. To review the performance of direct reports on a on a regular basis, and to provide direction on personal development requirements and appropriate action.

- To take responsibility for his/her own performance and take action to address identified personal development areas.

- Maintain good staff relationships and morale amongst the staff reporting to him/her, through effective feedback, recognition, appraisal and development.

- Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

- Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

- Promote the Trust's policies on 'equality of opportunity', and the promotion of 'good relations' through his/her own actions, and ensure that these policies are adhered to by staff for whom he/she has responsibility.

General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's Smoke Free Policy.
- Carry out their duties and responsibilities in compliance with the Health and Safety Policies and Statutory Regulations.
- Adhere to Equality and Good Relations duties throughout the course of their employment.
- Ensure the ongoing confidence of the public in-service provision.
- Maintain high standards of personal accountability.
- Comply with the HPSS Code of Conduct.

Information Governance

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including e-mails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Employees are required to be conversant and to comply with the Belfast Health and Social Care Trust policies on Information Governance including for example the ICT Security Policy, Data Protection Policy and Records Management Policy and to seek advice if in doubt.

For further information on how we use your personal data within HR, please refer to the Privacy Notice available on the HUB or Your HR

Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognizes the key principle that "Cleanliness matters is everyone's responsibility, not just the cleaners" Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff.

This includes:-

- Cleaning hands either with soap and water or a hand sanitiser at the appropriate times (WHO '5 moments');
- Using the correct '7 step' hand hygiene technique;
- Being 'bare below the elbows' when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);
- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Values

The Belfast Trust aims to recruit staff not only with the right skills but also with the right values to ensure the delivery of excellent patient care and experience. Staff will be expected to be committed to provide safe, effective, compassionate and person centered care by:-

- Treating Everyone with Dignity and Respect
- Displaying Openness and Trust
- Being Accountable
- Being Leading Edge
- Maximising Learning and Development

By embedding the above values we will make a significant contribution to the delivery of the Trust's Vision.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community were relevant, in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

Clause: ***This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.***

PERSONNEL SPECIFICATION

JOB TITLE / BAND: Governance and Quality Manager, Adult Social and Primary Care (Band 8A)

DEPT / DIRECTORATE: Adult Social and Primary Care

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined below at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA		
The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Experience **Qualifications** **Registration**	Have a University Degree or relevant professional qualification at Graduate or Diploma level **and** worked for at least 2 years in a senior management role Able to demonstrate evidence of successful leadership. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.	Shortlisting by Application Form

Other (e.g. Driving etc.)	Hold a full current driving license valid for use in the UK and have access to a car on appointment. *'Where disability prohibits driving, this criteria will be waived if the applicant is able to organise suitable alternative arrangements'*	Shortlisting by Application Form
Knowledge Skills Abilities	Have excellent communication skills, both orally and in writing.	Interview

DESIRABLE CRITERIA		
Desirable criteria will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these. Failure to do so may result in you not being shortlisted.		
Factor	**Criteria**	**Method of Assessment**
Experience Qualifications Registration	Previous Experience in a Governance role	Shortlisting by Application Form

NOTE:
Where educational/professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates *and* one photocopy of same issued by the appropriate authority. Only those certificates relevant to the shortlisting criteria should be produced. If educational certificates are not available an original letter *and* photocopy of same detailing examination results from your school or college will be accepted as an alternative.

If successful you will be required to produce documentary evidence that you are legally entitled to live and work in the United Kingdom. This documentation can be a P45, Payslip, National Insurance Card or a Birth Certificate confirming birth in the United Kingdom or the Republic of Ireland. *Failure to produce evidence will result in a non-appointment*.

Where a post involves working in regulated activity with vulnerable groups, post holders will be required to register with the Independent Safeguarding Authority.

Healthcare Leadership Competencies

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role.

The competencies concerned are set out in the NHS Healthcare Leadership Model,

details of which can be found at:

http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model.

Particular attention will be given to the following:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results

SENIOR MANAGER – SERVICE IMPROVEMENT AND GOVERNANCE

Location: Belfast HSC Trust

Contract: Temporary for 6 months

Salary: Band 8B

Hours: Full time

Interview Date:

JOB DESCRIPTION

Title of Post: Senior Manager, Service Improvement and Governance, Adult Social & Primary Care

Post Band: 8B

Reports to: Director of Adult Social & Primary Care

Responsible to: Chief Executive

JOB SUMMARY

The post holder will be responsible for leading and co-ordinating the service improvement and governance agenda within the Directorate.

The post holder will establish robust communication systems across the Directorate to disseminate and receive information about the service improvement and governance agenda and to enable all staff, service users and carers to participate in service modernisation.

The post holder will have line management responsibility for governance team, the senior management team administrative staff in the Directorate.

The post holder will work closely with the Co-Directors to ensure compliance with the governance agenda and will have lead responsibility for particular elements of clinical and social care governance.

The post holder will be the lead for liaison with RQIA for the Directorate.

KEY RESULT AREAS:

Setting Direction

- To take responsibility for ensuring that the service improvement and governance agenda is understood by staff and incorporated into everyday practice.
- To support Co-Directors by taking lead responsibility for ensuring that as the recommendations from the External Reviews are accepted, that they are communicated to and understood by staff, service users and carers and are implemented into practice.
- To ensure that evidence-based practice underpins all areas of service delivery.
- To encourage, support and promote service improvements within the Directorate.
- To work with the Co-Directors to ensure that information received as a result of complaints, user feedback or service reviews is used as a tool for service improvement.
- To support managers throughout the service in ensuring that users and carers influence service development and delivery.

Service Delivery

- To be managerially accountable and responsible for the governance and senior management team administration staff within the Directorate.
- To establish robust communication systems across the Directorate to disseminate and receive information about the service improvement and governance agenda and to enable service users, carers and staff to participate in the modernisation of services.
- To ensure that effective communication systems are in place across the Directorate to inform staff of service improvements and other areas of modernisation and reform.
- To take responsibility for ensuring that appropriate systems are in place within the Directorate for the management of Freedom of Information requests.
- To take responsibility for ensuring that appropriate systems are in place to manage responses to litigation.
- To take responsibility for timely and appropriate responses to RQIA.
- To establish a system for SAI process within the Directorate.
- To ensure that there is full compliance across the Directorate in relation to data protection, including access to health records.
- To ensure compliance with targets on complaints.
- To ensure that appropriate systems are in place to effectively respond to and learn from complaints.
- To take responsibility for identifying and implementing service improvement projects within the Directorate.
- To work with Co-Directors to take responsibility for ensuring that service reviews and audits are appropriately responded to and any necessary action taken.
- To take responsibility for ensuring that Directorate policies and procedures are developed, reviewed and communicated to staff.
- To take responsibility for ensuring that appropriate mechanisms are in place to involve users and carers in the planning and delivery of services.
- To take responsibility for ensuring that quality standards are developed and monitored in all areas of the service.
- To take responsibility for ensuring that appropriate mechanisms are in place to manage research governance within the Directorate. This includes supporting

and encouraging staff to develop research and development proposals and audits.

- To provide support as required to the associate Medical Director and Clinical Directors in the implementation of best practice.
- To work as an effective member of the Directorate senior management team.

Development and Innovation

- To take responsibility for enhancing existing user involvement strategies and ensuring that users and carers are appropriately supported to play a key role in the development and delivery of services.
- To lead in conjunction with Co-Directors, a reform and modernisation programme.
- To lead on quality initiatives and governance agenda.

Quality

- As the governance lead within the directorate, to ensure that appropriate quality standards and monitoring systems are in place across the services.
- To support the Co-Directors in ensuring that the Trust complies with all professional regulatory and requisite standards and the discharge of statutory functions.
- To ensure that the needs of users and carers are at the core of service delivery within the Directorate.
- To ensure that the pursuit of excellence is an integral part of the Directorate objectives, taking the lead in quality initiatives such as Investors in People etc.
- To support the Director and Co-Directors in ensuring that the Directorate meets legislative requirements as determined by the Mental Health Order.
- To lead the development of appropriate audit tools that monitor the quality of care to clients and patients in community and hospital services.

Professional Management

- To work closely with colleagues across the Directorate to embed service improvement and clinical and social care governance in everyday working practices.
- To maintain good working relationships with managers in other services and in corporate directorates to ensure a corporate approach to governance.
- To work closely with clinical and professional colleagues to support evidence-based practice and effective multidisciplinary working.

Financial and Resource Management

- To be responsible for managing the budget for the governance and senior management team and administration staff in the Directorate.

- To work within the Directorate budgetary constraints, providing advice on the costs and benefits of planned service improvements or other developments.

Leadership

- To contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
- To contribute to the Trust's strategy and to ensure that the service improvement and governance agenda meets both service group and corporate objectives.
- To promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures and appropriate personal behaviour.
- To ensure that management structures and practices support a culture of effective team working, continuous improvement and innovation.

People Management and Development

- To deputise for the Co-Directors when required.
- To delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- To support the development and implementation of workforce modernisation initiatives within the Directorate.
- To contributed as an effective member of the senior management team within the Directorate.
- To participate in the Trust's performance review scheme. To review the performance of those reporting to him/her on a regular basis and to provide direction on personal development requirements and appropriate action.
- To take responsibility for his/her own performance and take action to address identified personal development areas.
- To maintain good staff relationships and morale amongst the staff reporting to him/her, through effective feedback, recognition, appraisal and development.
- To participate as required in the selection and appointment of staff reporting to him/her in accordance with Trust procedures.
- To take such action as may be necessary in disciplinary matters in accordance with Trust procedures.
- To promote the Trust's policies on "equality of opportunity" and the promotion of "good relations" through his/her own actions and ensure that these policies are adhered to by staff for which he/she has responsibility.

General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- To provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- To demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- To comply with the Trust's No Smoking Policy.
- To carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- To adhere to equal opportunities and good relations policies throughout the course of their employment.
- To ensure the ongoing confidence of the public in service provision.
- To comply with HPSS code of conduct.

Records Management

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004 and Date Protection Act 1998. Employees are required to be conversant with Belfast Health and Social Care Trust policy and procedure on records management and to seek advice if in doubt.

Environmental Cleaning Strategy

The Trust's Environmental Cleaning Strategy recognizes the key principle that "Cleanliness matters I everyone's responsibility, not just the cleaners". Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff. This includes:-

- Cleaning hands either with soap and water or a hand sanitizer at the appropriate times (WHO "5 moments");
- Using the correct "7 step" hand hygiene technique;
- Being "bare below the elbows" when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);

- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Values

The Belfast Trust aims to recruit staff not only with the right skills but also with the right values to ensure the delivery of excellent patient care and experience. Staff will be expected to be committed to provide safe, effective, compassionate and person centred care by:-

- Treating everyone with dignity and respect.
- Displaying openness and trust
- Being accountable
- Being leading edge
- Maximising learning and development

By embedding the above values we will make a significant contribution to the delivery of the Trust's vision.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community where relevant, in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_ leaflet.pdf

Clause: **This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.**

JOB SPECIFICATION

POST: Senior Manager – Service Improvement and Governance

LOCATION: Belfast HSC Trust

ESSENTIAL CRITERIA:

Knowledge, skills and experience required:

- Applicants must provide evidence by the closing date for application that they are working in a substantive post in the Belfast HSC Trust
- Must hold a relevant health and social care professional or managerial qualification and worked for at least 3 years in a senior management role in a major complex organisation.
- Must be able to demonstrate knowledge of clinical and social care governance and experience of working with others to deliver service improvements.
- Must be able to demonstrate a working knowledge of Mental Health Order especially in relation to RQIA and the legislative requirements.
- Must be able to demonstrate evidence of a knowledge of health and social care service management including issues such as managing change, managing projects, workforce design etc.
- Must be able to demonstrate evidence of experience of financial management
- Must be able to demonstrate evidence of experience of administration management

VALUE BASED RECRUITMENT

Value Based Recruitment is a process adopted by the Belfast Trust to attract and select employees on the basis that their individual values and behaviours align with those of the Trust and incorporating the Healthcare Leadership Model.

It focuses on the “how” and “why” people do what they do.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required knowledge, skills, competencies and values to be effective in this new role.

In answering the value based questions you have the opportunity to share examples of when you have demonstrated values relevant to the Belfast Trust.

Belfast HSC Trust Values

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role.

RESPECT & DIGNITY

- Being respectful to others
- Showing compassion to those who are suffering
- Acting fairly and even-handed
- Acknowledging the good work of others
- Supporting others to achieve positive results

OPENNESS & TRUST

- Communicating openly and consistently
- Listening to the opinions of others and acting sensitively
- Being trustworthy and genuine
- Ensuring that appropriate information is shared honestly

ACCOUNTABILITY

- Taking responsibility for your own decisions and actions
- Openly admitting your mistakes and learning from them
- Using all available resources appropriately
- Challenging failures and poor practice courageously

LEADING EDGE

- Actively seeking out innovative practice
- Participate in new approaches and service development opportunities
- Share best practice with others
- Promote the Trust as a centre of excellence

MAXIMISING LEARNING AND DEVELOPMENT

- Act as a role model for the development of others
- Continuing to challenge my own practice
- Fulfil my own statutory mandatory training requirements
- Actively support the development of others

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT (final report)

TITLE:	Breakdown of [redacted]'s placement with Autism Initiatives (AI) and subsequent return to Muckamore Abbey Hospital
DATE OF SIGNIFICANT EVENT:	27th June 2019
DATE OF SIGNIFICANT EVENT MEETING:	12th August 2019
SEA FACILITATOR/ LEAD OFFICER:	Jacqui Austin
ATTENDEES:	Mrs [redacted] [redacted]'s mother ; Ms [redacted], [redacted]'s aunt; [redacted] Advocate; From the BHSCT Magda Keeling; Catherine Lynn; Rhoda McBride; Jacqui Austin, Dr Meekin; Dr Milligan; Frances Maguire; Eamonn Sherry; Autism Initiatives attendees Eamonn Slevin, Shane Hamill and Paula O' Doherty

WHAT HAPPENED?

[redacted]. was an inpatient in Muckamore Abbey Hospital (MAH) from 28/09/12 until his planned discharge to Autism Initiatives (AI), [redacted] Road Belfast on 11/02/2019, on a trial basis. [redacted]. was then re-admitted to Muckamore Abbey Hospital on the 27/06/2019, following a breakdown of his placement with AI.

In 2018 it was agreed [redacted] would benefit from moving to a supported living placement with Autism Initiatives (AI), which had been in the planning from early 2017 and Mrs [redacted] ([redacted] mother) commenced purchasing furniture for [redacted]s new accommodation. Dr Humphries and Catherine Close considered the [redacted] Road premises to be a suitable placement for [redacted]

Mrs [redacted] and the family were very happy, content and approved of all that was being done. Everyone agreed this was the right decision for [redacted] albeit an unknown experience. Mrs [redacted] attended the multi-disciplinary meetings and transitions meetings, apart from 1 meeting that apparently the delayed discharge was discussed.

In January 2018 the in-reach visits commenced by AI staff to [redacted] in Muckamore Abbey Hospital. This was to enable [redacted] to get to know the new staff who would be caring for him and for AI staff to gain knowledge and observe [redacted].'s routine and his personality. This also allowed MAH nursing staff to impart information and guidance to AI staff ahead of [redacted].'s discharge.

Danielle McIlroy; Community Social Worker was involved in meetings and communication regarding ’s planned discharged at this time and during his period of time in the Road.

In-reach visits to MAH and contact with ceased between March and October 2018 due to staffing levels within A.I. As AI were having difficulty recruiting staff into the posts.

In November 2018 there was a joint Trust & AI decision to suspend the discharge from Muckamore Abbey Hospital for a period of time due to the difficulty AI was experiencing with staffing levels. Mrs was not present at this meeting. Mrs was aware of the recruiting problems AI were experiencing.

It was considered that the delayed discharge and cessation of the in-reach visits caused P275 to become anxious and confused.

On the 11th February 2019 was moved to Autism Initiatives as planned and he seemed to settle in quite well at the beginning, albeit continued to have periods of unsettled behaviour, although in the main the staff managed these incidents quite well. Shane Hamill was Service Manager and built a good relation with and Mrs . They had constant contact at the initial stage of placement although as time progressed communication was less frequent.

As time progress became very unsettled and was having more incidents of unsettled behaviour towards other service users and staff. These incidents occurred while on the premises and once while travelling in the car.

There was a gradual decline in previously settled behaviour and co-operation until the placement was in crisis in June 2019. Mrs was not aware of the incidents or the severity and stated she did not wish to be made aware of these incidents. At this stage was being managed on a 2-1 supervision. The incidents occurred both day and night and AI received additional funding for night supervision.

had a car purchased in March 2019 available for his use during his time with AI and initially this was seen as positive as enjoyed his time on outings in the car. However, there was overuse of the car and it was stated that it appeared to be used as a way of managing behaviours. However A.I manager did not agree that this car was been used to manage behaviour. But everyone agreed that was in the car for extended periods during the day, every day.

Mrs expressed that she agreed that one factor leading to ’s deterioration was the overuse of the car. This was confirmed by ’s aunt Ms who felt AI staff allowed to demand trips in the car even when it was not appropriate. It also transpired the car had to be hidden from ’s view to avoid becoming upset. s mother and aunt felt the car was a trigger point for his unsettled behaviour at 10pm.

fell following a breath holding attack, which had also happened in Muckamore. It is unsure if this was noted in his care plan. But AI confirmed that as part of his assessment prior to moving into

Road they were not informed that he did this. Mrs ████ was not informed of either. The Trust acknowledge that it had not informed AI or included this in ██'s care plan.

Dr Meekin visited ██ at his ███ Road home to offer support/guidance to staff and management on the 29th May. At this point Dr Meekin did not have huge concerns about the placement. There were some challenges and staff ratio was increased to 3-1 supervision. Although AI admitted this was difficult to maintain given the limited staff resources available.

Shane Hamill advised on the 13th June 2019 there was an incident in which ██ was locked in his bedroom for 3 minutes to allow another service user to proceed to their bedroom. On the same day AI staff locked themselves in the living room due to the nature and severity of ██'s behaviour.

AI staff used assertive commands in an attempt to resolve the situation and if unsuccessful medication was given PRN. Mrs ████ noted this is not within the guidelines, ie PRN should be given as soon as possible after assertive commands are unsuccessful.

Following a request by Shane Hamill at the end of June, Dr Milliken reviewed and increased ██s PRN medication for dental pain. This happened in the last week of the placement.

On the 19th June 2019, following an incident AI management advised the Trust they could no longer support ██'s placement as it was unsafe for ██, other service users and staff. At this time AI had 3 members of staff on sick leave due to the injuries they sustained while supervising ██ AI requested an admission for assessment and withdrew care so staff from ████████ Hospital were sent to care for ██ until, his re-admission.

On the 27th June 2019 ██ was re-admitted to ████████ Hospital under article 15 of the Mental Health Order and his placement was rescinded.

AI apologised for the re-admission and that the placement had not worked out for ██

WHY DID IT HAPPEN?

AI National Director advised recruitment was difficult at this time due to the labour market constraints and competition with other employers. He went on to say that as a charitable organisation and a private provider of supported living care they can only recruit once a new resident has an approved placement. He also said that in an effort to help recruitment AI implemented changed terms & conditions that included increasing pay levels earlier in the year.

██.'s care-plan at the time of his discharge for his trial period was 2-1 but on reflection it is now felt it should have been 3-1 and this was discussed at the transition meetings with the Director and Co-Director.

██. had dental pain and was unable to vocalise this, which may have contributed to the deterioration

in his behaviour as commented by the dentist to Mrs [redacted] and AI.

AI staff used the car outings to manage [redacted]'s behaviour, resulting in [redacted] spending a lot of his day in the car driving around and only returning to have his meals, medication and at bedtime.

Communication between all the parties declined during the last few months prior to, leading up to and during [redacted]'s placement. This situation was very confusing for all and an anxious time for [redacted]'s family.

Rhoda McBride and Dr Milliken advised that [redacted] was a detained patient under the Mental Health Order and as such remained under the care of [redacted] Hospital and therefore any concerns should have been raised with [redacted] Hospital.

WHAT HAS BEEN LEARNED?

Whilst Mrs [redacted] stated that she would not wish to be made aware of every incidents of unsettled behaviour or of the injuries caused by [redacted] to other service users, himself and staff, she felt she should have been listened to, as she knows his trigger points. The keyworker needs to be known to the family, and be able to build up a relationship with the family.

AI never implemented 3:1 supervision as it was only recommended on the 21 June 2019 and [redacted] had transferred back to [redacted] Hospital on the 27th June 2019. It was felt that this type of supervision is not a true reflection of a normal environment. Roles and responsibilities need to be defined.

The speed and manner of any intervention following a deterioration of behaviour has a huge impact on a successful outcome and continuation of the placement. At all times there needs to be openness and honesty.

[redacted] was experiencing dental pain, which would have been a contributing factor to the deterioration in his behaviour. This should have been picked up by AI sooner as they were told on numerous occasions.

A review of the care plan should have taken place much sooner to reflect the concerns and the interventions required to manage the placement and a follow up discussion before restrictive practice was introduced.

The family needed to be informed and involved in all MDT review meetings regarding [redacted] so an informed decision could be reached.

The Trust accepted a collective approach to support the placement up to 3 years.

In-reach meetings should have an appropriate number of attendees. The family felt the meetings

were not affective because of the number of staff attending.

All relevant details and incidents should be recorded in the care plan and should be accurate.

There needs to be connectivity when a patient is discharged to a supported living environment.

The Trust needs to understand systems and structures of AI.

Review of AI's policy on staff training for behavioural issues and reflect on the introduction of Positive Behaviour Support (PBS). Was there the numbers of staff with these skills?

Use of Behavioural Specialist and discussion if AI could best meet ███'s needs.

Community team involvement required before the deterioration in May.

AI confirmed expectation of working alongside and in partnership with the Trust community teams, such as crisis intervention, as they do in other Trusts and services.

The car should not have been used as a behavioural tool and was not in the patient based action plan (PBA).

Rhoda McBride and Dr Milliken advised that ███ was a detained patient under the Mental Health Order and as such remained under the care of Muckamore Abbey Hospital and therefore there should have been regular reviews involving AI and Muckamore Abbey Hospital.

A summary of what has been learnt

Planning

- During the period of in-reach and out-reach AI should have identified if they would meet ███'s needs.
- AI need to acknowledge the impact of difficulties in recruiting staff and the impact this had on the placement. Open and honest discussion needs to take place.

Communication

- Mrs ███ felt isolated from communication between AI and Muckamore Abbey Hospital.

Care Plan

1. M.A.H. did not provide enough information on ███s care plan prior to discharge.
2. The care plan should have been reviewed on a monthly basis by AI when behavioural challenges became an issue. AI agreed with this and stated they review their support plans and

care plans in partnership with the Trust.

3. The consideration of dental pain should have been made by AI a little sooner.
4. The concerns about the placement should have been escalated sooner and Mrs [redacted] felt this was a very important point.
5. Using the car as a way of managing [redacted]. is totally unacceptable. He was often in the car for periods of up to 8hours.
6. Before a new piece of equipment (ie a car) is introduced restrictive practices need discussed and created. Mrs [redacted] emphasised the importance of this point.

WHAT HAS BEEN CHANGED?

P275 remains an in-patient in [redacted] Hospital.

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

The planning stage is vital to establishing exactly what is needed to progress the placement.

The family must be involved in All decision making processes.

The care plan must accurately and contemporaneously reflect care needs of the individual.

The Trust needs to understand what conversations AI management had with their staff regarding behavioural therapy as there was such a fast deterioration in the placement within a 2 week period.

AI is happy to expand on this with the Trust and this will be shared with Mrs [redacted].

Jenni Armstrong

18th October 2018

Agenda

- Audit – Risk assessments – Update
- SDR
- BRAAT 3 review group - update
- Policies – update
- Learning letters
- Case review – timeline
- Training requirements
- Office accommodation

Belfast Health and Social Care Trust
caring supporting improving together

ANNUAL STAFF DEVELOPMENT REVIEW

Name of Person Being Reviewed:	Jenni Armstrong	Reviewer / Manager	Jacqui Austin
Job Title / Band:	Band 6 Resource Nurse	Job / Title / Band	Service Improvement and Governance manager
Date of meeting:	15/10/2018		

Review Of Previous Year

Discuss areas of greatest and/or least satisfaction over the past twelve months. This discussion should reflect upon all achievements including KSF, individual objectives and contributions, PDP and how the Trust values have been demonstrated in undertaking your day-to-day role and interactions with others.

From March to September 2018, I was in a Nurse Development Lead post, which had been advertised as an expression of interest. In September 2018, I returned to work within the governance team as a resource nurse for mental health & learning Disability within Adult Social and Primary Care. My duties include RQIA link within LD services, Care plan development and education, quality improvement, report writing in relation to incidents and the use of restrictive, Paris ongoing development and troubleshooting, overseeing the review of policies for LD. This post continues to provide me with professional development and I am committed to lifelong learning through internal / mandatory / external training. I regularly receive professional supervision as I maintain registration with the NMC.

respect & dignity

openness & trust

leading edge

learning & development

accountability

Knowledge & Skills Framework (KSF) Development

CORE KSF dimensions and their level	Provide examples to show knowledge & skills (Examples can include work activities, feedback ,observations, records of work, information from supervision and training undertaken)	Development Areas
1 Communication	Attendance at risk resister, nurse documentation and other meetings. Report writing – incidents, use of seclusion and physical intervention Presentations Training of staff in care planning. Verbal and written communication via phone, face to face, email	Attend SEA training and meeting Attend Governance meeting
2 Personal and people Development	Mandatory training Learning disability forum Delivering care plan training to staff Sharing of skills, knowledge and experience with others	Be actively involved in the shared learning forum
3 Health, safety and security	Adhere to Trust and Regional Policies, Procedures and Guidance Attend relevant training.	Attend fire training Be involved in learning letters
4 Service improvement	Involvement in regional LD Nursing assessment Paris processes and documentation - on going service improvement	Work with Paris development team on projects
5 Quality	Ongoing audits on patients documentation Generation of reports for analysis	Attend advanced excel training
6 Equality and diversity	Promote quality and diversity and non-discriminatory culture across the service area	Complete mandatory training on equality and diversity and DDA training

Specific KSF dimensions	Apply appropriate legislation, policies and procedures in all aspects of work.	
	Click or tap here to enter text.	Click or tap here to enter text.

Individual Objectives & contributions Individual objectives/contributions for the year ahead (include target completion date). The Trust priorities should be considered – Safety, Quality and Experience; Service Delivery; People and Culture; Strategy and Partnerships; Resources.
Assist in the development of the LD regional assessment on Paris Participate in team involved in SAI reviews Attend SEA training and meetings Attend Recruitment and selection training Be involved in BRAAT 3 Develop role within Paris development

Personal Development Plan Include all development needs which may arise from the knowledge and skills framework, key objectives for the post, continuing professional development requirements, career progression, application of the Trust values and statutory/mandatory training.	Planned date of completion
Attend SEA training and meeting Complete SAI/SEAs as case review officer Attend Governance meeting – expand role within LD Governance group Be actively involved in the shared learning forum Attend fire training Be involved in learning letters Work with Paris development team on projects Attend advanced excel training Complete mandatory training on equality and diversity and DDA training Attend a shared learning review group with line manager Attend policy writing course	Click or tap here to enter text.

Signature of Reviewee:	Jenni Armstrong	Date:	19/10/2018
Signature of Reviewer:	Click or tap here to enter text.	Date:	Click or tap to enter a date.

BELFAST HEALTH & SOCIAL CARE TRUST

Minutes of the Intellectual Disability Services Governance Meeting

Wednesday 18 January 2017 at 11.00 am
Conference Room, Everton Complex

Present:
Mrs. Mairead Mitchell, Acting Head of Learning Disability Services
Ms. Jacqui Austin, Senior Manager, Service Improvement and Governance
Dr. Karen Humphries Consultant Psychiatrist, Learning Disability Services
Dr Colin Milliken, Clinical Director, Learning Disability Services
Miss Patricia Minnis, Quality and Information Manager
Mrs. Karen Cunningham, Lead Health and Safety Manager, Corporate Risk Governance
Mrs. Esther Rafferty, Service Manager, Hospital Services
Mr Maurice O'Kane, Planning and Performance Manager
Ms. Aine Morrison, Service Manager, Community Treatment and Support Services
Miss Rachael O'Connor, Quality Assistant (minutes)

Apologies:
Dr Maria O'Kane, Associate Medical Director
Dr Sarah Meekin, Head of Psychology Services

Item	Outcome of Agenda Item Discussed	Action & Lead
1.0	**Minutes of the Previous Meeting**	
	Minutes of the previous meeting were agreed.	
2.0	**Matters Arising**	
	2.1 Physical Interventions (SCIP Training)	
	Mairead advised she had met with Sarah Meekin, Head of Psychology Services and they had agreed to go forward with MAPA in community. Service managers to provide names of staff in the community to be trained as trainers. Mairead advised that a group will be established for the implementation of MAPA. Dates will follow.	**E. Rafferty** **M. Mitchell**
	2.2 Governance Structure	
	Mairead advised those present that amalgamating Learning Disability Services and Mental Health Services for Governance was found to be not effective. Learning Disability Services will have their own independent Governance Meetings. Mairead informed those present that Mr Cecil Worthington has advised that he is recommending to the Chief Executive that Adult Social and Primary Care Services	

should have their own director. A co-director for each service area (Mental Health, Learning Disability and Older Peoples Services is also recommended).
It was noted that the following groups will remain as part of the governance structure:

Mental Health Order Group
NICE Implementation Group
Risk Register Group

Jacqui advised that the Audit Lead Group and Mortality and Morbidity Group may combine. Jacqui to provide an update at next Intellectual Disability Services Governance Meeting. **J. Austin**

It was agreed that the Intellectual Disability Services Governance Meeting should take place 3 times a year.

3.0 Dashboard

Jacqui updated those present on the Intellectual Disability Services Dashboard up until the end of November 2016.

SAI's – It was noted that there were 0 SAIs within the service this year compared to 3 from last year.

Incidents – Jacqui advised those present that Intellectual Disability Services still had the highest incidents in abusive, violent, disruptive or self-harming behaviour; this is due to the nature of the incidents with patients for the service.

Complaints – Jacqui advised the complaints figures had a noticeable drop in November 2016. Jacqui also advised that Intellectual Disability's compliance with 20 working days target needed to improve. Jacqui and Louise Moore, Complaints Manager have agreed to meet with services as a support and to try and improve response times.

Compliments – There were 0 compliments in November 2016.

RQIA Inspections – Those present noted the number of unannounced inspections that had taken place since April 2016.
Jacqui advised that for the assurance committee the requirements were now to be documented as "met / not met" (this will be included in the report for the assurance committee).
Mairead advised that given the number of inspections that had taken place the recommendations in general were low and staff were to be commended for this.

RIDDOR – 7 injuries over 3 days, this figure was down from the previous year.

Absence Report – 8.24%, this had increased from previous month.

4.0 Risk Register

Jacqui advised those present that the draft report from internal audit had been issued and would be circulated with staff when finalised. Jacqui advised those present that some comments were constructive.

Discussion ensued about the Intellectual Disability Risk Register and how to make a working document.

It was noted that risks should be able to be traced through the management plan. Jacqui to discuss this at next Senior Managers Group. Those present noted that the register should not contain risks from as far back as 2008. Further work on the Risk Register to be actioned by service managers.

J. Austin

Service Managers

5.0 RQIA

Those present noted the Baseline Assessment and Review of Community Services for Adults with a Learning Disability within their papers. Aine to take forward.

A. Morrison

6.0 Health & Safety

Those present noted the following points on the Health and Safety briefing:

Karen advised that if a member of staff identifies a health and safety concern an internal process has to be followed, full details of this process are on page 1. Karen asked this information be cascaded to staff.

Window Restrictors - Karen advised that a learning letter will be produced in relation to an incident involving a patient using substantial force to break the hinge on a window that was restricted, posing a risk of injury/death from fall from height.

Purchase and Installation of Equipment - Karen advised the guidance attached had arisen following an incident within Acute Services; she asked that this be considered and implemented as necessary.

ALL

BRAAT Update – Karen advised that Adult Social Primary Care Directorate were the currently the best Directorate with a 100% return rate. Karen advised that she would be available to follow up directly with any staff that had red or amber outstanding within their audit plan.

Stress Focus Workshops – Karen advised that there would be stress focus workshops available for Intellectual Disability Services.

A. Morrison
E. Rafferty

Slip Incident – With reference to the incident whereby a Homecare worker slipped on an icy pavement when visiting an elderly patient. Procedures have now been put in place for staff and patients to be provided with appropriate footwear, especially for the use of walking

within hospital grounds. Mairead advised those present that Service Managers order the appropriate footwear for staff and patients. **A. Morrison E. Rafferty**

Managing Shift Work – Those present noted the minimum requirements regarding shift work. Jacqui asked this be considered on the risk register.

Those present noted the Annual Health and Safety Report, April 2015 – March 2016. It was noted this report is now available on the hub.

7.0 SAI's

7.1 Revised Procedure for the Reporting and follow up of SAI's – November 2016

Those present noted the document contained within their papers.

7.2 Introduction to HSC Never Events List

Those present noted the Never Events List. It was discussed that in the event of a Never Event causing an SAI that the family should be informed, however it was discussed that families may not understand the Never Event. Mairead advised those present that this information should be circulated to staff at team meetings. **ALL**

8.0 Policies

Table of Policies Approved and Standards and Guidelines Care Pathways by Trust Committee. This document was noted by those present. Jacqui advised that these documents had now been uploaded onto the Hub.

Local Guidance for Facilitating Visits by Children to Mental Health and Intellectual Disability Inpatient /Residential Facilities – This policy was noted by those present. Esther advised of one change – six mile in Muckamore Abbey Hospital to be included in references relating to low/high secure units. Mairead asked those present to return any comments to Patricia within one week otherwise this procedure would be taken as approved. **ALL**

9.0 Trust Smoke Free Policy

Esther advised those present that Muckamore was due to implement the Smoke Free site on Friday 10th March 2017. It was agreed that there will be an expected increase in complaints when this is implemented as was the case following its implementation in Mental Health Services.

10.0 Mortality and Morbidity

Those present noted the report within their papers. No outstanding action for Intellectual Disability Services.

11.0 Any other Business

Patient Safety Alert – Reducing the risk of oxygen tubing being connected to airflow – This was noted although it does not currently pose an issue for this service.

12.0 Date, time and venue of next meeting

The next Intellectual Disability Services Governance Meeting will take place on Wednesday 17th May 2017, 11am, Conference Room 1 Fairview.

BELFAST HEALTH & SOCIAL CARE TRUST

Minutes of the Intellectual Disability Services Governance Meeting

Wednesday 10 May 2017 at 11.30 am
Conference Room 1, Fairview

Present:
Mrs. Mairead Mitchell, Acting Head of Learning Disability
Ms. Aine Morrison, Service Manager, Community Treatment and Support Services
Ms. Jacqui Austin, Senior Manager, Service Improvement and Governance
Mrs. Karen Cunningham, Lead Health and Safety Manager, Corporate Risk Governance
Ms. Aishing Curran, Service Manager, Residential, Supported Living and Day Care Services
Mr Michael McBride, Senior Nurse Manager, Hospital Services
Miss Rachael O'Connor, Quality Assistant (minutes)

Apologies:
Dr Sarah Meekin, Head of Psychology Services
Mrs. Esther Rafferty, Service Manager, Hospital Services
Dr. Karen Humphries Consultant Psychiatrist, Learning Disability Services
Miss Patricia Minnis, Quality and Information Manager
Dr Colin Milliken, Clinical Director, Learning Disability Services

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Item	Outcome of Agenda Item Discussed	Action & Lead
1.0	**<u>Minutes of the Previous Meeting</u>**	
	Minutes of the previous meeting Wednesday 18th January 2017 were taken as read.	
2.0	**<u>Matters Arising</u>**	
	2.1 Physical Interventions (SCIP Training)	
	Mairead advised those present that a meeting will be scheduled in forthcoming week regarding MAPA/SKIP for community services.	
	Aine expressed concerns regarding changes as the focus for Skip is an keen emphasis on understanding behaviours. Mairead acknowledged this and an update to be given at next Intellectual Disability Services Governance Meeting.	**M.Mitchell**
	2.2 Governance Structure	
	Jacqui advised those present that a workshop will be set up in June to discuss combining some of the Governance Groups eg. Audit. Jacqui advised that this will be chaired by medics. Jacqui to update at next Intellectual Disability Services Meeting.	**J.Austin**

Mairead advised that a meeting has been set up for Quality Improvement, Learning Disability, Mairead to invite Jacqui to this group. **M.Mitchell**

Mairead asked for Dr O'Kanes name to be removed from the Intellectual Disability Services group as medical representation is present. **R O'Connor**

3.0 Dashboard

Jacqui updated those present on the Intellectual Disability Services Dashboard up until the end of March 2017.

SAI's – It was noted that there was 1 SAI within Intellectual Disability Services compared to 3 from last year. Jacqui advised those present that the current SAI was completed and due to be submitted. There was no learning and no recommendations arising from the review.

Incidents – Jacqui advised that abusive, violent, disruptive or self-harming behaviours were still the highest incidents within Intellectual Disability Services.

Complaints – Whilst figures for Intellectual Disability Services were low compared to other areas, response times could still be improved when dealing with specific complaints.

Compliments – There were 0 compliments recorded for March 2017, discussion ensued were the compliments were being sent as Governance Department has received 0 since November 2016.

RQIA Inspections – Those present noted the number of inspections that had taken place since April 2016. Mairead advised that it would be beneficial to include an additional column, failure to comply. **R.O'Connor**

RIDDOR – 6 injuries over 3 days, 0 major injuries for the period January 2017 – March 2017.

Absence Report – 8.67%, this had increased from previous months.

4.0 Complaints

4.1 Management of Complaints 2016/17

Those present noted the document from internal audit within their papers, Jacqui advised those present that the trust had received a satisfactory response with dealing with complaints. Jacqui advised that the response times within Intellectual Disability Services had a 60% response rate within the 20 days, Jacqui acknowledged that staff had worked well on improving this target, and resolving complaints locally, staff involved should be commended for this.
Mairead and Jacqui advised that should a complaint be received it should go straight to Mairead in the first instance and then through Jacqui who will deal with it via the complaints process.

Mairead advised she had a process in place with Lesley to follow up and make sure all outstanding complaints have been actioned.

Aine expressed concerns regarding the next of kin details and legitimate interest within patients/complaints. Regarding obtaining the most appropriate person to contact and communicating with same.

4.2 C/792/16 – Patient should know who is providing their care

Jacqui advised those present of the learning letter contained within their papers. This was a complaint from a patient that staff were not wearing their name badges. Jacqui advised those present of the importance of this for all service areas so the patient knows who is providing their care.

5.0 Risk Register

Those present noted the Intellectual Disability Services Risk Register. Jacqui advised those present that this was an excellent risk register and a huge amount or work had taken place to streamline this.

6.0 RQIA

6.1 Baseline assessment and review of community services for Adults with a Learning Disability

Mairead advised those present that this was currently on hold. Mairead to provide an update to Jacqui for next Learning Disability Services Governance Meeting. **M.Mitchell**

Jacqui advised those present that restraint and seclusion thematic review group was completed yesterday. There was good representation and feedback from all services.

7.0 Health & Safety

Karen advised those present on the following points on the Health and Safety briefing noted for May 2017:

Window Restrictors – Karen advised that this is now an article within the Safety Matters News Sheet.

Sensory Equipment – Karen advised that a letter will go out across the organisation regarding procurement advice.

BRAAT 2 Validation Visits – Karen advised those present that the validation visit for community teams was completed on 12th April 2017, however this visit did not go as well as expected due to the limited evidence presented on the day. It was discussed that 4 separate audits were not suitable for community teams, it was also mentioned the need for a separate document for the community. Karen advised this would be discussed at next Health and Safety meeting. **K.Cunningham**

New Occupational Hygiene Service for Belfast Trust – The trust has appointed IQARUS to provide new service, this service is available as part of COSHH and General Risk Assessment review process, further details can be obtained by clicking on the link provided within the document within papers.

HSE Launches its new draft Health and Work Strategy and plans - The following 3 draft plans are in process of and what HSE are doing to reduce cases of:

- Work related stress
- Musculoskeletal disorders
- Occupation lung disease

RIDDOR – There was a slight decrease from previous year 2015/2016.

Review/Substitution of a Substance of a very High Concern (SVHC) – Flowchart – Those present noted the flowchart contained in the Briefing Note.

8.0 SAI's

8.1 SAI/16/069 – Patient Treatment Plans must be clearly documented and communicated to the multi-disciplinary team

Those present noted the document contained within their papers. Jacqui outlined the importance of generic learning for all services, documentation must be clearly communicated in all service areas. Mairead also outlined the importance of this particular learning letter being distributed for hospital issues regarding treatment plans for outpatients.

8.2 SAI/16/078 – Loose Fitting Dentures should be identified as a hazard, particularly when a patient has a poor swallow

Jacqui outlined the learning letter above regarding dentures that had not been identified in a patients throat until 15 weeks later; the family had reported the dentures were lost. Loose fitting dentures were not recorded as a hazard on admission.

BHSCT W127803 - Patients personal details in all formats, must be held securely and disposed of in accordance with the Trusts Records and Retention Policy

Those present noted the document contained within their papers. Those present were reminded to inform staff especially within the community settings of holding onto patient's personal details.

8.3 Shared Learning Template

Jacqui advised that a new group has been set up, "Shared Learning Review Group", which will include mainly corporate and **J.Austin**

directorate governance mangers. Jacqui to feedback on next Intellectual Disability Governance Meeting.

9.0 Policies

Those present noted the 3 outstanding policies with Intellectual Disability Services:

- Personal Alarm Systems on the Muckamore Abbey Hospital
- Supervision/Observations within Learning Disability Inpatient Services
- Securing Patient/Client Records following a Serious Adverse Incident within Adult Social and Primary Care

Mairead advised those present she would check the positon of the above policies. **M.Mitchell**

10.0 Trust Smoke Free Policy

Those present discussed the Trust Smoke Free Policy and the non-compliance with the policy. Particular reference was given to detained patients within the Mental Health and Learning Disability Wards. To be kept under review.

11.0 Mortality and Morbidly

Those presented noted the report contained within their papers, it was noted that Intellectual Disability Services reporting on MMR was minor.

12.0 Any Other Business

Adult Safeguarding Report – Aine advised there was an increase in figures.

Mairead asked that the following reports be made available for the next meeting:

- Adult Safeguarding
- Statutory Functions Report

Discussion ensued on the hospital passport and how this is rolled out within the hospital setting. To be taken forward at next Senior Managers Meeting. **M.Mitchell**

Mairead advised that another Intellectual Disability Services Governance Meeting to be arranged for September 2017. Rachael to set up. **R O'Connor**

13.0 Date, time and venue of next meeting

The next Intellectual Disability Services Governance Meeting will take place on Wednesday 13th September 2017, 9.00am, Conference Room 1 Fairview.

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	**Intellectual Disability Services Governance Committee**
PURPOSE	To provide assurance to the Adult Social and Primary Care Directorate Governance Committee that there are effective structures, systems and policies in place for the management of all aspects of the Governance Agenda in Intellectual Disability Services.
MEMBERSHIP	**Chair:** Head of Intellectual Disability Services Divisional Chair, Intellectual Disability Services **Membership: -** Head of Intellectual Disability Services Senior Manager, Service Improvement and Governance Divisional Chair, Intellectual Disability Services Service Manager, Muckamore Abbey Hospital Divisional Nurse, Intellectual Disability Services, Divisional Social Worker, Intellectual Disability Services, Service Manager, Residential, Supported Living and Day Care Services Service Manager, Community Treatment and Support Services Head of Psychology Services Health and Safety Manager Carers Consultant Quality and Information Manager **In attendance:** Any Senior Professional or Senior Manager within the directorate or Trust will, where appropriate, be invited to attend. **Secretary:** Quality and Information Assistant. **Member Appointments:** As per the management and professional appointments

DUTIES	To provide a Forum that reports on all aspects of Governance within Intellectual Disability Services; Ensure that clear lines of accountability and responsibility exist within Intellectual Disability Services for the overall quality of care; Ensure the co-ordination and prioritisation of Intellectual Disability Services risk register, and provide reports to the Directorate's Governance Committee when required. To monitor the incident reports, complaints and compliments and ensure that staff within Intellectual Disability Services are supported in learning from incidents, complaints and compliments; To receive reports including examples of good practice and innovation and agree the way forward for any future recommendations and actions; Ensure all staff within Intellectual Disability Services are provided with adequate governance information, training and education; To promote an open and participative culture of partnership working with patients, clients and the community To receive the Statutory Functions Report and discuss as appropriate
AUTHORITY	Authorised by the Directorate's Governance Committee to review any activity within its terms of reference. It may seek relevant information from any: • Employee; • Other Committee, subcommittees or group established within the Trust Assurance Framework to assist in the delivery of its functions
MEETINGS	**Quorum** The quorum for the meeting will be the Chair (or Deputy) plus no less than 60% of the membership. Should a member be unavailable, they may nominate a deputy to attend in their place subject to the agreement of the Chair. **Frequency of Meetings** The Committee will meet four times per year and agree a schedule of meetings at least 12 months in advance. Additional meetings will be arranged as determined by the Chair.

	Papers Agenda and papers will be disseminated to Committee Members four working days before the date of the meeting and wherever possible, electronically.
REPORTING	The Committee is accountable to the Directorate's Governance Committee for its performance in exercising the functions set out in these terms of reference. The Committee, through its Chair and members, shall work closely with other Trust Steering Groups and Committees in the Assurance Framework. In doing so, the Committee shall contribute to the integration of good governance across the Directorate, ensuring that all sources of assurance are incorporated into the Trust's overall Risk and Assurance Framework.
CONFLICT/ DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting of the committee.
REVIEW	These terms of reference and operating arrangements will be reviewed on at least an annual basis by the committee. May 2018

BELFAST HEALTH & SOCIAL CARE TRUST
INTELLECTUAL DISABILITY SERVICES GOVERNANCE MEETING
WEDNESDAY 12th DECEMBER 2018 @ 3pm
CONFERENCE ROOM 1, FAIRVEIW

MAHI - STM - 248 - 87

AGENDA

1.0 Apologies

2.0 Minutes of last meeting held on 12th September 2018

3.0 Matters Arising
- 3.1 Controlled Drugs Audit

4.0 Dashboard (October 2018)
- 4.1 Medication Incidents within Intellectual Disability Services in the Community

5.0 Incidents Reports
- 5.1 Incidents on Transport to Day Centres (January – June 2018)
- 5.2 Quarterly Incident Report (1st July – 30th September 2018)
- 5.3 Incidents, Safeguarding and use of Physical Intervention and Seclusion MAH October 18

6.0 Service Manager Governance Reports

7.0 Complaints
- 7.1 RAG Report

8.0 Statutory Functions

9.0 Risk Register
- 9.1 New risk – 80 Malone Road
- 9.2 New risk – Changes in National dysphagia texture descriptors

10.0 Health and Safety
- 10.1 Health and Safety Briefing Note

11.0 Serious Adverse Incidents
- 11.1 Engagement with families in the event serious adverse incident reviews involving a homicide
- 11.2 Learning Letter - Staff concerns regarding patient care, need recorded, raised and escalated appropriately

12.0 O'Hara Inquiry

13.0 Policies and Procedures
- 13.1 Complementary Therapy Policy

14.0 RQIA
- 14.1 MHO Spot Check (31st report)
- 14.2 Final Inspection methodology 2018/19

15.0 Any Other Business
- 15.1 BRATT
- 15.2 Annual Quality report 2017/18
- 15.3 Information Governance Bulletin
- 15.4 Ligature Risk Survey – Outstanding actions

16.0 Date of Next Meeting – 13th March 2019 at 11.00 a.m. in Conference Room 1, Fairview

ASSURANCE FRAMEWORK COMMITTEE

TERMS OF REFERENCE

COMMITTEE	Muckamore Live Governance Meeting (skype)
PURPOSE	To provide assurance to the directorate that all governance information is analysed and acted upon in a timely manner
MEMBERSHIP	**Chair:** Chair of Division **Membership:** - Clinical Director (co- chair) Governance Manager Nursing Senior managers Charge Nurses/Ward Sisters Band 7 **In attendance:** Any Senior Professional or Senior Manager within the directorate or Trust will, where appropriate, be invited to attend. In the event of unavoidable absence from a meeting, each member must nominate an appropriate deputy to represent them. The Chair should be notified of any deputies.
DUTIES	• To work collaboratively with the MDT to ensure patients' and staff safety is a priority in Muckamore • To review all incidents/ complaints and adult safeguarding incidents in Muckamore Abbey Hospital • Provide support to Charge Nurses/Ward Sisters by reviewing investigations carried out • To identify any learning To share learning through:- • Shared learning forum • Learning letters • Governance meetings • Professional Nurse Forum

MEETINGS	**Quorum** Minimum of seven members including two Senior Nurse Managers **Frequency of Meetings** The meetings will be weekly **Papers** Report template will be shared with the group prior to the meeting
REPORTING	• The chair of the group will report to the Co-Director, Governance meeting on a quarterly basis • Escalate appropriately any concerns identified through appropriate reporting lines
CONFLICT/ DECLARATION OF INTEREST	The Chair shall seek and record any declaration or conflict of interest from members prior to every meeting of the committee.
REVIEW	These terms of reference and operating arrangements will be reviewed initially within 6 months of the first meeting

Date: ___________________ **Ward:** _________________

Adverse Incidents	Comments / Actions
SAIs (those incidents that meet the SAI criteria)	Comments / Actions
Complaints	Comments / Actions
Restrictive Practices (P.I: Seclusion: Rapid Tranquilisation)	Comments / Actions
Adult Safeguarding Incidents	Comments / Actions